An Interpretive Phenomenological Analysis of Interprofessional Education; An investigation of the experiences of pre-registration healthcare students

by

Mark Gradwell

Canterbury Christ Church University

Thesis Submitted for the Degree of Doctor of Education

2021

Contents

Thesis Body Word Count: 55290

Abstract

This research study explores the way in which pre-registration healthcare students experience interprofessional education (IPE) using Interpretative Phenomenological Analysis (IPA). The research involved four pre-registration healthcare students at CCCU from two year groups who experienced IPE delivered in different ways. Two participants were midwifery students, one participant was an occupational therapy student and one was an adult nursing student. Semi-structured interviews were held to facilitate a guided conversation. Each participant was interviewed on two separate occasions eight months apart. Interviews were recorded and transcribed. Transcripts were analysed and emerging themes were identified and examined, with the researcher considering and reflecting on his own interpretation.

New knowledge has emerged from this research with regard to the impact of how facilitators communicate with students during IPE, the extent to which IPE activities can impact on student's self-awareness and the impact that race and diversity may have on the student experience of IPE. Findings from this study have also reinforced the findings of previous studies including how having contact with students and professionals from different groups positively affects how members of other professional groups may be perceived, can improve working relationships and that hierarchy exists both between professional groups and within professional groups.

The recommendations from this research are considered to be of interest to both academic and clinical staff. Due to the idiographic nature of IPA, this research offered an insight into the local context and specific programmes. However, it is suggested that findings might be used to positively inform the development of IPE programmes and activities more broadly, as they highlight some of the issues associated with IPE that result in students having a positive, or conversely negative experience of IPE.

Acknowledgements

There are a number of people that have each played a crucial role in helping me on the journey to completion of this thesis.

My thanks go to my wife Sharon and my children George and Gemma who have supported me throughout. They have put up with me being away on study weekends, last minute rushes to meet deadlines, and my bad moods and grumpiness when the stress has got to me. At the lowest points when I was all for giving up, it was they who rallied me and motivated me that it would all be worth it, and to just carry on.

My fellow students in the EdD 2015 cohort have been a source of constant support and encouragement. Regular e-mails and WhatsApp messages was a reminder that I was not the only one going through this. Particular thanks to Jen and Karen for being a sounding board and always willing to listen and advise.

My supervisor Sue Soan has provided constant, patient and unwavering academic and pastoral support, and has always been there to give guidance and advice and keep me focussed. Likewise, my thanks go to Bob Bowie for his insightful and valuable feedback at review times.

My former and current Head of School, Kate Springett and Chris Burton have sponsored me – without their provision of funding and allowing me study time during the thesis stage I would not have been able to undertake the EdD.

A special thanks to my sister-in-law, Kirsten and my brother-in-law, Simon who both took time out of their busy lives to proof-read my manuscript and provided valuable assistance in the final editing. I know this was a big ask and you are both stars in my eyes!

Finally, my thanks go to the students who gave their time to participate so enthusiastically in this study and so freely and candidly opened up to me and gave me an insight into their experience of IPE. Their names have been changed but Amy, Beth, Jo, and Meg – you know who you are!

1.0 Chapter 1. Introduction

1.1 Introduction

This chapter aims to provide a context for Interprofessional Education (IPE). The importance and rationale for IPE in a global context and in the UK is discussed. Information about how IPE is delivered in the Faculty of Medicine, Health and Social Care at Canterbury Christ Church University (CCCU) is provided.

1.2 IPE

"It is no longer enough for health workers to be professional. In the current global climate, health workers also need to be interprofessional." (World Health Organisation, 2010)

IPE is defined in several ways in the literature. The WHO's (2010) definition of interprofessional education suggests bringing students from different disciplines together in a variety of ways to learn how to work as teams. The Centre for the Advancement of Interprofessional Education (CAIPE) in 1997 initially defined Interprofessional Education as: occasions when two or more professions learn together with the objective of cultivating collaborative practice (CAIPE 1997). In 2002 the definition was amended to: "occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care". In 2017 CAIPE extended their definition to include students and recognised interprofessional education as "occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services" (CAIPE 2017). It is this definition which seems most cited and accepted. The key factor in using the term 'inter-professional' is the involvement of members (or students) of more than one profession.

Distinct from Interprofessional Education is Intraprofessional Education. Intraprofessional has been defined as training professionals in the same field to work together in a collaborative manner (Nardella 2018) and the learning that occurs when individuals of two or more disciplines within the same profession engage (Teheux et al 2021). While the principles of inter and intraprofessional learning are similar at a core level, the key difference between the two is the presence of members (or students) of the same profession in the latter. However these members (or students) must be of different grades or specialisms.

The premise of IPE is that it enables individual professionals to improve their own practice to complement that of others, informs joint action to improve services and instigate change, and improves outcomes for individuals, families and communities (Barr and Lowe, 2011).

Internationally, The World Health Organization's "Framework for action in interprofessional education (IPE) and collaborative practice" (World Health Organisation 2010) promoted IPE as a key strategy to enhance patient outcomes. The World Health Professions Alliance took the position that education programme accreditation requirements should address the need to facilitate shared learning and to prepare graduates for interprofessional collaborative practice (ICP) (World Health Professions Alliance 2019). They proposed that pre and post registration education programmes should adopt a philosophy of ICP and include opportunities for joint and person-centred, problem-oriented learning and professional socialisation, in both clinical and academic environments (ibid).

The professional regulatory bodies have had a significant impact on interprofessional education in the UK. These include the Health and Care Professions Council (HCPC) who regulate members of 15 health and care professions in England, Wales, Scotland and Northern Ireland, and the Nursing and Midwifery Council (NMC) who are the nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland. The HCPC requires programmes "must ensure that learners are able to learn with and from, professionals and learners in other relevant professions." (HCPC 2018). Likewise the NMC will "only approve programmes where the learning culture is ethical, open and honest, and is conducive to safe and effective learning that respects the principles of equality and diversity. Innovation, inter-professional learning and team working should be embedded in the learning culture." (NMC 2021)

1.3 IPE at CCCU

The Faculty of Medicine, Health and Social Care at CCCU offers pre-registration professional programmes that integrate interprofessional education (IPE) into their curriculum. The interprofessional learning programme at CCCU was first developed in 2009, was expanded in the 2012 revalidation and further adapted in the 2017 revalidation. Two students involved in this study enrolled on their programme of study in April 2017 and followed the 2012 curriculum. The other two students involved enrolled on their programme of study in September 2017 and followed the 2017 curriculum.

The Faculty of Medicine, Health and Social Care's agreed principles of IPE have been derived from the Principles of Interprofessional Education (Barr and Lowe 2011):

- Collaboration is essential for professional practice
- Collaboration improves outcomes for the individual, families and communities.
- Collaboration enables joint action to improve services and instigate change.

These principles are an acknowledgement that programmes aim to develop students who are not only confident in their own professional competence and identity but who are also aware of the skills and expertise of other colleagues with an understanding that working with others improves outcomes for all.

In the 2012 programme students studied one Collaborative Practice (CP) module per year and one Professional Development (PD) module per year. The other 4 modules studied per year were pathway specific. The CP modules – CP 1, 2 and 3, were delivered in two interprofessional event weeks and two day-long seminars throughout the year. Students were allocated to a group with students from other professional groups. The CP seminars were facilitated by a member of faculty staff who may or may not be of the same profession as the students in their group.

In the 2017 programme there are no core collaborative practice modules. Rather the emphasis is on the separate, individual programmes embedding interprofessional education (IPE) into the curriculum delivery in both theoretical modules and practice, with a greater emphasis on linking the theoretical learning to IPE experiences in the practice environment. Students are provided with IPE opportunities through the provision of 'core' days to engage in classroom-based IPE activities as an essential component of their programme. These 'core' days are organised with a combination of large group 'conference' style and small group workshop delivery. The programmes have each developed their own interprofessional learning strategies. To enable students to explore interprofessional working and explore their own professional identity and the roles of fellow health and social care professionals, they have the opportunity to interact with students from other professions whilst at university. Students have specific interprofessional placement experiences and have workbook learning activities to assist them in learning about other professions.

1.4 Context and Rationale

I am a diagnostic radiography educator. This means that I consider myself to be a 'dual professional' and these two aspects to my professional life no doubt influenced the direction that this research took and my initial decisions to investigate the issue that I did.

Radiography is described by the College of Radiographer as 'an exciting, fulfilling career that bridges advanced technology with patient-centred care.' (CoR 2022). As such a diagnostic radiographer has two fundamental roles – one technical and one caring. It is this combination that differentiates a radiography professional from being a technician or a carer. The technical aspect of the role revolves around the production of the diagnostic image using highly technical equipment, an understanding of radiation protection and a knowledge of how to position a patient in order to obtain an optimal

diagnostic image. The caring aspect to the role involves communicating sensitively and compassionately with patients, adapting positioning techniques to accommodate any special needs they may have. It is this aspect which is explored in some depth when we interview individuals who apply for a place on the course. We want to ensure that students who join the course have the values and personal qualities to be able to become caring practitioners.

However, in my experience of over 20 years as a radiography educator, I have come across a contradiction which develops as students progress through their programme of study. Whilst we are keen to promote the caring element of the role at the outset, as students commence and proceed with the course, the importance of the technical element of the role seems to become a priority. The production of the image seems to become the perceived primary role of the radiographer. When I ask students what they think a patient wants or expects from their visit to the x-ray department, they often reply along the lines of 'their x-ray to be taken correctly' or 'a good diagnostic image'. I then get into a conversation about how surely the expectation of a good diagnostic image is a 'given' – similar to if they take their car to the garage they expect the fault to be fixed – but actually what makes a 'good' experience is if it 'felt' good – which relates to how you were treated, how you were spoken to. And the crucial thing is that an experience is how the patient perceives it and can only be explained by the patient. This is the importance of the patient voice.

Likewise in education we can evaluate educational activities such as courses, modules or events in a number of ways. Often we evaluate if an activity is 'good' or not by looking at results of assessment or attendance. We can also ask students to complete a questionnaire or survey. However these are often closed questions, multiple choice offering specific responses or likert type responses. The actual experience is how the student perceives it and can only be explained by the student. This is the importance of the student voice.

I have come to realise whilst considering the approach to this research the importance that I place on 'hearing the voice' in order to truly understand an experience.

A few months before me taking up post as IPE director, the approach to IPE within the faculty had changed. A revalidation process had resulted in the removal of the 'common' CP modules which students on all pre-registration healthcare programmes studying the 2012 curriculum were required to study. There were a number of reasons given for the change in approach, but it was often anecdotally commented that the modules were unpopular with staff and students and that they had consistently evaluated poorly, that engagement was not good and that the material was deemed by some to be irrelevant to the programmes being studied. This gave me an opportunity to investigate the student experience of these modules from the student perspective – to hear their voice.

However I am a radiographer and I cannot ignore the other element that guides me – the technical, scientific aspect. I enjoyed science at school and it was the scientific aspect of diagnostic imaging that was a strong driver in me choosing radiography as a career in the first place. Scientific research is based on structure, protocols and being able to 'measure' things, so it wasn't enough just to be able to listen to the student voice – I wanted to be able to analyse the data in a rigorous and systematic way. IPA provides an organised and structured way to thoroughly analyse the data but also requires interpretation and imagination to create meaning from the data. Thus I felt excited by the process enabling me to satisfy myself on both fronts.

It was also important to look to the future. I knew that this study would take some time before I produced any findings. Every five years health courses undergo periodic review and revalidation by the relevant professional bodies. The HCPC requires programmes "must ensure that learners are able to learn with and from, professionals and learners in other relevant professions." (HCPC 2018) and the NMC require "inter-professional learning and team working should be embedded in the learning culture" (NMC 2021). The courses will be required to be reviewed in 2022/3 and I knew that the experiences of students on the existing courses could be informative and influential in developing how the faculty approaches IPE in the future

1.5 Summary

This chapter provided a definition of Interprofessional Education (IPE) and the importance of IPE in a global context and in the UK was explained. Information about how IPE is delivered in the Faculty of Medicine, Health and Social Care at Canterbury Christ Church University (CCCU) is provided. The participants in this study either studied the 2012 validated curriculum or the 2017 validated curriculum. The differences between the two programmes were explained. Finally the context and rationale for the study was provided.

2.0 Chapter 2. Literature Review

2.1 Introduction

This chapter explains the process adopted to review the literature to inform the research study. Inclusion and exclusion criteria are provided, and the critical appraisal method described. Literature relating to the experiences of healthcare students of IPE in the UK and Europe is explored. The review of the literature is presented by the themes which emerge from the literature.

2.2 Literature Review Process

CCCU's library search engine LibrarySearch was used in the literature search. LibrarySearch can access a number of subject databases relevant to this subject area including Cinahl, Medline, Science Direct and Scopus. Although LibrarySearch accesses other databases, the search did not provide any results from any databases other than Cinahl or Medline (or where results were found these were duplicates to those found in Cinahl and/or Medline). The Boolean/phrase search terms interprofessional education AND experiences AND healthcare students were used. Search limitations applied were English Language and Publication from 2010 to 2021. The search strategy and results can be seen in Table 1.

Table 1; Search Strategy and Results

Database name	**Key words/phrases used**	**Search limits**	**No. results**
CINAHL (Cumulative Index to Nursing and Allied Health Literature)	interprofessional education AND experiences AND healthcare students	2010 – 2021 English Language	131
MEDLINE (Medical Literature Analysis and Retrieval System Online)	interprofessional education AND experiences AND healthcare students	2010 – 2021 English Language	38

The articles were sorted in order of relevance and then reviewed manually for their suitability for inclusion in the review by title, then abstract, then full text reading.

2.3 Inclusion and Exclusion Criteria

Being mindful of the qualitative approach to this study, only qualitative studies were included in the review. Studies employing quantitative or mixed methodology approaches were excluded. The context of this study being UK based was also an important consideration. Education of healthcare students varies widely across the world and likewise professional standing and scope of practice varies from country to country. Although there has been a significant number of studies considering the student experience of IPE performed in Australia, the USA, Canada and other parts of the world, for this reason studies originating from outside the UK and Europe were excluded. Only studies published from the year 2010 onwards were included with a recognition of the importance of those studies being reviewed being contemporary and reflective of the current situation and practices in health professional education. Only papers published in English were reviewed for practical translation reasons. Only papers published in professional, peer reviewed journals were included. This was to ensure the quality and 'provenance' of the literature reviewed. The literature search and appraisal produced a total of 25 papers to review. A table summarising the papers included in the review can be found in Appendix 1.

2.4 Critical Appraisal Method

Holland and Rees' (2010) qualitative critiquing framework was used to evaluate the quality of the research presented and to ensure a structured and consistent approach to critiquing the research. Papers were not excluded solely on their quality.

The literature review is presented by the themes that emerged from the literature which are facilitation, awareness of others and self, communication and teamwork and hierarchy and power.

2.5 Facilitation

Participants in IPE have identified facilitation of the activity, programme, module or event as being a crucial aspect in their experience of IPE. In the context of IPE, facilitation may be considered to be the actions associated with encouraging, enabling, guiding and supporting students through planning, organising, and managing the educational process including the provision of opportunities, resources and an appropriate environment.

2.5.1 Mixing with others

Providing the opportunity to mix with students from other professions has been identified as an important aspect of the facilitation of IPE by several authors. Kaldheim et al (2021) suggested that from a social interaction perspective, knowledge is created through interaction between people, and

individual learning is a product of participation in activities with others. Telford and Senior (2017) explored the barriers and enablers to engagement in IPE in a focus group-based study of twelve occupational therapy and child, mental health and learning disability nursing students. Thematic analysis of the focus-group data revealed that the participants valued working with people from other disciplines and that this contact was beneficial to preparation for clinical practice. However, participants in Telford and Senior's (2017) study also highlighted the importance of having students from the same profession as them within the IPE group. Participants described feeling isolated if they were the only student from their profession in the group, which resulted in a reluctance to participate in the IPE session. Participants also talked of an 'emotional apprehension' of IPE and a fear of working with an unfamiliar team. Telford and Senior (2017) suggested this highlighted the importance of facilitators considering students' feelings and emotions before the start of the IPE session and creating a safe and non-threatening learning environment.

Likewise, in Allen et al's (2014) study, students on a combined nursing and social work degree reported feelings of alienation, isolation, and exclusion. However, this was seen to be as a result of the social work aspect of their programme largely being ignored in the larger lectures of the nursing common foundation programme, because it was reported as being difficult to include these aspects for a relatively small number of students and exclude the majority. It may be argued that this is a matter of facilitation – the authors acknowledge that "the teaching and learning strategy was seen to represent a methodology that was determined more by organisational system and less by the inclusive principles of interprofessional student-centred education" (Allen et al 2014 p 5). In order to compensate for omitted content from the large group lectures the students had to attend additional lectures delivered specifically to their small group. This led to the perception that nursing and social work students were being taught separately and thus there was a lack of inclusion, and also that the that nursing and social work students had to work harder than students on other nursing programmes. The authors suggested that this had a two-fold effect; the dual learning enabled a deeper understanding of both nursing aspects and social work aspects but correspondingly, by being taught the two separately, a division was created through reducing the opportunity to mix with students from other professions (Allen et al 2014).

Osman (2017) analysed themes emerging from focus group sessions involving twelve medical students discussing their previous experiences of IPE and their perceptions of what affects the success of IPE. Their findings mirrored those of Telford and Senior (2017) in that students described enjoying previous experiences in which they worked with a good mix of professionals. However, conversely, they talked of 'missed opportunities' when sessions involved an unbalanced mix of students where there were more medical students than those from other professions, and

suggested that these sessions had little benefit over uniprofessional experiences (Osman 2017). Similar findings emerged from a study by Hallin and Kiessling (2016) who conducted narrative analysis of free-text answers to questionnaires distributed to medical, nursing, physiotherapy and occupational therapy students as part of an evaluation of an interprofessional training ward (IPTW). Students described it was 'fun, safe and instructive to belong to a team with other students' but also commented on the importance of the make-up of student teams. Students described how a team missing a student profession felt incomplete, but likewise teams that were dominated by too many students from one profession led to issues relating to that profession taking precedence over others, and that there was less opportunities for each student from the dominant profession to practice their role (Hallin and Kiessling, 2016 p 144).

Roberts and Goodhand (2017) investigated the learning from an interprofessional ward simulation of adult nursing, diagnostic radiography, occupational therapy, physiotherapy, dietetics, and pharmacy students using focus groups. Participants in this study highlighted that being enabled to mix with students from other professions helped take them out of their professional 'silos'. The authors reported how students appreciated the 'social situation' that the IPE experience facilitated and talked of how being able to just 'chat' with others had helped break down barriers between professions and helped them to overcome stereotypes.

Stephens and Ormandy (2018) talked of 'group dynamics' emerging as a theme from their study involving nursing, radiography, physiotherapy, social work, and podiatry students describing their experiences of IPE in focus groups. Students reported on the benefits of being able to learn from, with, and about each other and the development of a 'learning alliance' between students (Stephens and Ormandy 2018 p 352) and commented on the positive dynamics within the groups.

Derbyshire and Machin (2011) carried out a phenomological study and interviewed adult nurses with six months post-qualifying experience about the impact of IPE in university on their practice as students and as qualified practitioners. Participants also reported how they had valued opportunities to learn in small groups with a mix of different professions represented. The study concluded that IPE opportunities in small interprofessional interactive groups were acknowledged as the most effective learning and teaching approach (Derbyshire and Machin 2011).

Tran et al (2018) conducted focus groups with nursing, physiotherapy, occupational therapy and medicine students who had clinical placements in primary healthcare. IPE was perceived to be important by all participants and they asked for more opportunities. Students said that they appreciated meeting and having discussions with students from other professions, however this rarely happened. Students commented that they did not meet other students during their clinical

placements, and they said it seemed contradictory that they did not see or collaborate with each other during their education, and yet they were expected to collaborate later when they had graduated.

2.5.2 The influence of the facilitator

The influence of the actions and behaviours of the facilitator on the experience of IPE has also been emphasised. The knowledge and skill of the facilitator has been found to be crucial to a positive experience of teaching and learning in IPE, in particular in ensuring equal opportunities for learning for all student groups (Telford and Senior 2017). Whiting et al (2016) reported that their study revealed the lecturer role to be fundamental for the support of student learning. Students in Whiting et al's (2016) study also highlighted the importance of facilitators involved in IPE delivery having appropriate skills in managing group dynamics, conflict and ensuring inclusiveness. Students in Hallin and Kiessling's (2016) study valued the supportive attitude shown by facilitators who enabled them to act independently, gave instructions when needed and provided encouragement and feedback. Students particularly commented on 'the safe culture', created by supervisors who were 'pedagogically and clinically experienced' and 'readily available' (Hallin and Kiessling's, 2016 p 144)

Kaldheim et al (2021) explored Norwegian perioperative nursing students' experiences of interprofessional simulation-based learning through focus group interviews. The students highlighted the importance of a facilitator who 'took responsibility and guided them' through the IPE activity (Kaldheim et al 2021 p 178). Echoing Telford and Senior's (2017) observations on the importance of the knowledge and skills of the facilitator, students in Kaldheim et al's (2021) study stated that the competence of the facilitator was crucial. Students also referred to the need for facilitators who could provide specific profession-oriented information, be competent in the subject being covered in the session and able to reflect clinical practice (Kaldheim et al 2021 p 181). Students in Allen et al's 2014 study similarly identified the competence of the facilitator as crucial. Allen (2014) found that students on the combined nursing and social work degree were left 'with a deep sense of frustration' (Allen 2014 p 9) when lecturers were only able to deliver lectures within the boundaries of their own professional expertise. Allen et al (2014) concluded that lecturers, practice educators, and mentors, must be 'professionally multilingual' so that they can 'embrace and communicate' effective collaboration (Allen et al 2014 p 10).

From a narrative analysis of evaluations completed by physiotherapy, nursing, dietetics, radiography, radiotherapy, medicine, social work and complementary therapy students of IPE experienced in practice placements, Kelley and Aston (2011) observed that variation in facilitator styles can complicate student learning, and proposed joint training of facilitators may help to reduce this.

The ‘learning alliance’ between students engaging in IPE discussed by Stephens and Ormandy (2018) also stretched to the relationship they had with their facilitator. The students reported benefitting from interactions where the facilitator engaged with them ‘as equals’ and where there was an apparent ‘flat hierarchy’. This issue of the importance of the student-facilitator relationship was also highlighted by Clancy et al (2020). Using an IPA approach to investigate the experiences of mental health nursing, adult nursing, clinical psychology and medical students of Schwartz Rounds as an IPE initiative, Clancy et al (2020) identified the role of facilitators in enabling students to feel safe to share and discuss their experiences (Clancy et al 2020 p 290). However, conversely, some students in the study described feeling less safe to share, due the presence of lecturers, with concerns expressed about the power that lecturers have over students and that that confidentiality could not be assured.

O’Carroll et al (2016) conducted a literature review of health and social care professionals’ attitudes to interprofessional working (IPW) and IPE. They concluded that as potential facilitators of IPE in the workplace, clinical staff are key role models for students and have a role to play in ensuring that that IPE is seen to be valued. This resonated with the findings of Williamson et al (2011). Using telephone interviews with key educational stakeholders in Health Trusts and Strategic Health Authorities, and focus groups with midwifery, dietetics, podiatry, occupational therapy, physiotherapy, adult nursing and paramedicine students, they concluded that for IPE to be effective, it needs local facilitation and structures that support it. Whiting et al (2016) concurred with the value of clinical mentors in enabling and supporting IPE when they found that whilst students did learn about IPW by spending time observing and shadowing other professionals, nurse mentors play a key role in facilitating IPE opportunities in the clinical environment.

From a narrative analysis of reflective statements and unprompted observations by medical, midwifery, nursing, occupational therapy, operating department practice, pharmacy and physiotherapy students of an interprofessional shadowing visit, Wright et al (2012) highlighted the influence that IPE facilitators can have on the perception by students of their own and others’ professions. They concluded that all interactions between students and experienced professionals are likely to impact on students, and discussions within the shadowing visit can affect students’ perceptions of the profession within the team (Wright et al 2012 p 309). Telford and Senior (2016) agreed and reported that academic or clinical staff who are involved in IPE need to be aware of how their attitudes and opinions can influence students. Likewise, findings from a Danish phenomenological study involving focus group interviews with final year nursing students conducted by Bahnsen et al (2013) identified the influence of the attitude of clinical staff to IPE on students. Bahnsen et al (2013) proposed that students can be influenced by qualified practitioners lack of

understanding of the relevance of IPE and develop negative expectations and perceptions to IPE themselves. In support of this students in Tran et al's (2018) study reported that their clinical supervisor's support and attitudes to IPE was crucial and could be either an enabler or barrier to IPE. Students found it important that all staff in their placements were good role models for IPE, commenting that if their supervisor interacted with other professions the students also wanted to do so.

The role of facilitators in the development and maintenance of student's professional and moral values and identities, resilience, and confidence to challenge practice has been highlighted by Monrouxe et al (2014). A study of interprofessional learning using narrative analysis of interview transcripts of dentistry, nursing, pharmacy and physiotherapy students suggested that through role playing, educators can facilitate and encourage students to face moral and professional dilemmas. Courtenay (2013) agreed that an understanding by facilitators of teaching methods that promote interprofessional interaction is vital to encourage knowledge sharing and collaborative practice between groups. Courtenay (2013) proposed that differences in knowledge acted as a barrier to learning. Medical students, in her study of IPE activities involving nurse prescribing and medical students, reported that they did not contribute to discussions for 'fear of appearing patronising' (Courtenay 2013 p 94).

2.5.3 Relevant and Realistic

Another important element of facilitation of IPE is the perceived relevance of the subject matter being covered. The medical students in Osman's (2017) study reported 'clinically relevant learning' as being one of the positive experiences of IPE. They engaged well with experiences that they perceived to be 'realistic' or 'relevant' to their future professional practice but likewise they complained about 'generic teambuilding' activities and this negatively affected their engagement in the sessions. In accordance with these findings, nursing students in the study conducted by Bahnsen et al (2013) commented on the relevance of their experiences of placement on an Interprofessional Clinical Study Unit (ICSU). Findings suggested it was important that the students could see some relevance of their IPE experience and integrate what they had experienced into their conventional placements. Bahnsen et al (2013) reported that some students noted that the tasks from their IPE experience were different but complemented the tasks they were expected to carry out during their usual placements. However, others thought it was inappropriate that tasks in the IPE placement and their usual placements were not identical and were of the opinion that they were unable to use the learning from the IPE placement. Bahnsen et al (2013) suggested the challenge for educators and facilitators is to make it clear to the students how intraprofessional and interprofessional skills are

complimentary, and both are necessary for solving the patients' problems (Bahnsen et al, 2013 p 42).

Roberts and Goodhand (2017) reported that students were 'overwhelmingly positive' about the IPE ward simulation activity since they could see how it related to practice and it linked how the professions need to interact and work together. Hallin and Kiessling (2016) echoed those findings. Students reported the interprofessional training ward to be an 'enriching interprofessional learning environment' and the students particularly welcomed the opportunity to take care of 'authentic patients in real-life situations' (Hallin and Kiessling, 2016 p 143). These resonate with the findings of Kaldheim et al (2021) who reported that participants in their study emphasised that a realistic environment and equipment were prerequisites for IPE involving simulation to be successful. They reported that participants who experienced IPE as realistic found it easier to immerse themselves in the simulation case but that participants who experienced IPE as unrealistic lost focus during the simulation session (Kaldheim et al 2021).

Derbyshire and Machin (2011) suggested IPE should be as practice focused as possible to improve its relevance to practice and that educators 'continually seek authenticity in IPE material to reflect the reality of the practice setting'. Interestingly participants placed a high importance on having students from other 'relevant' professions involved. The authors reported how some participants in this study expressed concern that the absence of students from professions that they had experience of working with in practice hindered their interprofessional learning. These opinions were echoed by the children's nursing students in Whiting et al's (2016) study who suggested that the inclusion of midwifery and medical students in the IPE activities they experienced would have been beneficial. Likewise Kaldheim et al (2021) reported that students in their study felt that the simulation they experienced as part of an IPE activity should include the same professions as would be found in clinical practice and Hallin and Kiessling (2016) reported students described how a team missing a student profession felt 'incomplete'.

2.5.4 Design, Delivery and Organisation

Facilitation in terms of the design, delivery and organisation of IPE can influence responsiveness of students to IPE. Small-group sessions have been reported as being highly valued by students, who feel such sessions allow learning to be integrated with that of students from other professions and helped to create an interactive and engaging learning environment (Telford and Senior, 2017; Allen et al, 2014 and Osman, 2017).

Monrouxe et al (2014) have commented on the value of role play in IPE activities and this finding is in agreement with the views expressed by participants in Derbyshire and Machin's (2011) study who expressed a desire for more role play with patient scenarios, but felt that developing IPE into the practice setting would be even better (Derbyshire and Machin 2011 p 241). The benefit of embedding IPE in practice education has likewise been cited by others (Kelley and Aston, 2011; Williamson et al, 2011 and Whiting et al, 2016). Kelley and Aston (2011) argued that IPE is most effective when experienced in clinical practice whilst students are working together. Wiliamson et al (2011) suggested that embedding IPE into practice settings is essential in order to promote effective joint working between health and social care professionals. Students in Whiting et al's (2016) study stated that whilst they valued the IPE modules, whilst on placement they were actually able to see IPW and that 'seeing it in practice makes it more real rather than sitting and talking about it' (Whiting et al, 2016 p 24).

Although not something identified by students in their study, Kelley and Aston (2011) did acknowledge that clinical realism may cause stress amongst students but suggested that this may be avoided by enhancing existing practice learning experiences rather than creating new activities such as unique interprofessional training wards. This highlighting of anxiety around participating in IPE and how this can relate to design and delivery corresponds with the findings of Telford and Senior (2017). Participants in Telford and Senior's (2017) study commented that the anxieties caused by the thought of engaging in IPE were reported as not being helped by having the IPE sessions spread over a few weeks. Kaldheim et al (2021) have commented on the importance of educators preparing students for IPE activities in order to reduce unnecessary stress and making it easier for students to focus on essential learning objectives. Kaldheim et al (2021) refer to Yoo and Kim (2018) who have described 'flow' as an optimal mental state in which people engage in 'a short period of immersive experiences while doing activities'. They suggest one way of improving 'flow' is to orient learners to where the activity is similar to clinical practice and where it is different (Kaldheim et al 2021 p 185). Kaldheim et al (2021) also highlighted the essential role of post-activity debriefing to support student learning through IPE activities and that debriefing should clarify learning objects. Kaldheim et al (2021) argue that reflective thinking in debriefing is essential, and that in IPE, participants can develop problem-solving skills through reflective thinking.

Telford and Senior (2017) also reported that timing and frequency of IPE sessions was a potential barrier to the success of IPE. Participants in the study felt that the scheduling of the events (2 hours a week over 3 weeks) allowed students to disengage, suggesting the delivery of IPE events is important with respect to scheduling. Wright et al (2012) also commented on scheduling of IPE. They identified a limitation of their study was that the shadowing visits experienced by their participants

were only a single half-day. They proposed that repeated or more lengthy opportunities for shadowing different healthcare professionals could provide better insight into working with others. Similarly, participants in Osman's (2017) paper discussed timing for IPE events and suggested that there should be multiple interprofessional events throughout the undergraduate course. Findings of Kaldheim et al's (2021) study agreed, with students in their study requesting interprofessional simulation based learning to be scheduled more frequently and regularly throughout their programme.

Courtenay et al (2013) conducted focus groups with nurse prescribing and medical students. Key themes that emerged from the study included scheduling of classes, location of the sessions and balancing of participating students. These were all considered to be potential barriers to learning. One student described an experience of being the only nurse in a group with eight medical students and how she felt intimidated (Courtenay et al 2103 p 94). This resonated with later findings by Telford and Senior (2017) regarding feelings of isolation expressed by students if they were the only student from their profession in a group. Almås and Vasset (2016) investigated the IPE experiences of first and third year nursing, biomedical laboratory scientist and social education students using text analysis of students' written assignments and online discussions. Almås and Vasset (2016) suggest that IPE should be introduced early in programmes before 'professional doctrines' have been adopted, and to positively influence students' attitudes towards future collaborative practice. However, they recognised that IPE interventions should be tailored more precisely to students' stages of development. They proposed that findings from their study suggested IPE in the first year could be focussed on insight into competence in their own and other professions whereas IPE in the second year could be focussed on collaborative practice (Almås and Vasset, 2016 p 120).

2.6 Awareness of Others' and Own Roles

Telford and Senior (2013) found that students felt that meeting with people from different professional backgrounds was valued and beneficial to preparation for clinical practice, and Whiting et al (2016) found that students believed that IPE gave them insight into the roles and responsibilities of others. Lecturers and mentors in the study emphasised the value of learning about the roles of other professionals and how patients benefitted from a collaborative approach to care and it was suggested that studying with peers from other professional groups helped to avoid 'misconceptions about what others do' and break down 'barriers' (Whiting et al, 2016 p 24).

Nursing students in Bahnsen et al's (2013) study expressed that they learned about the other professions during interprofessional teamwork activities, and how they contributed to the treatment and care of the patient. Bahnsen et al (2013) proposed that when role based relationships of shared

goals, shared knowledge, and mutual respect are established, participant engagement with the situation and each another is increased, and concluded that 'role-based relationships and relational bureaucracy promote universalistic norms of caring' (Bahnsen et al, 2013 p 41).

Almås and Vasset (2016) proposed that students have the ability to acquire knowledge about other professions' roles and responsibilities through participating in IPE. They suggested that students who participated in IPE had a greater appreciation of the value of interprofessionalism. Similarly Telford and Senior's (2013) study found students spoke positively of the opportunities that IPE provided to enable them to develop a greater understanding of others' roles, of learning how they may interact with them in practice in future and how they enjoyed working with, and learning from them. Telford and Senior (2013) concluded that IPE offers the potential to significantly change students' perceptions of other professions and when this is achieved, students are able to use this knowledge and understanding to inform their clinical practice. Osman (2017) found that there was a perception amongst students in his study that IPE enables them to gain more awareness of the role of others and result in improved collaboration. Roberts and Goodhand (2017) found that students reported that IPE enabled them to learn about others' roles, to see how professions can work together and how their professions fitted in to the bigger picture. Importantly students in Roberts and Goodhand's (2017) study commented on developing respect for each other's profession and their role through the IPE activity.

Afseth and Paterson (2017) explored interprofessional competency assessment of nurse non-medical prescribing students by doctors. They reported that the non-medical prescribing students and their supervising doctors suggested that shared learning occurred during the period of assessment and that involvement in the activity resulted in a 'trust' developing between the professional groups and an understanding of the views of the other profession. This concurred with Kelley and Aston's (2011) finding that student's experience in their IPE activity identified that better understanding of other's roles within the multiprofessional team contributes to better patient care through effective collaborative working. Likewise, Wright et al (2012) found that having shadowed a health professional from another professional group, students were able to reflect upon different roles within an interprofessional team and consider how their own future role might contrast and complement that of the healthcare professional they shadowed. Derbyshire and Machin (2011) reported that all students in their study felt their understanding of their own roles and that of others had been improved through engaging in the IPE activity. Similarly, the nursing students in Bahnsen et al's (2013) study found that they increased knowledge of their own profession and learned about the importance of interprofessional teamwork from their IPE experience. Marcussen et al (2018) concluded that IPE activities appeared to develop positive attitudes toward other professions and

improve knowledge and skills in collaboration. They also proposed that changes in students' behaviour and organisational practices as a result of IPE interventions may have a positive impact on patients (Marcussen et al, 2018).

Alsio et al (2019) explored healthcare professionals' experiences of implementing clinical education of medical students in a Swedish hospital using focus groups made up of doctors, nurses, and nurse assistants. They reported that awareness of the roles and responsibilities of students and other healthcare professionals was found to support engagement, whereas lack of awareness was found to counteract engagement. They also proposed that interprofessional interaction was found to be an important mechanism for learning among individual staff members and that collaboration and the learning climate may be enhanced by interprofessional learning.

Hallin and Kiessling (2016) proposed that students developed an increased self-confidence and knowledge about themselves during an interprofessional training ward experience. Students in their study talked of 'becoming confident regarding their professional choice and they developed a belief in their ability to be a good professional in the future' (Hallin and Kiessling, 2016 p 145). Hallin and Kiessing (2016) claimed that through the IPE activity, students developed confidence in their choice of profession, faith in the competence of other professions and a comprehensive view of patient care.

Kaldheim et al (2021) suggested that students begin to shape their professional identity through participation in an interprofessional simulation-based learning activity. They proposed that the development of professional identity is influenced by perceived future responsibilities, and it is essential that learning relates to situations that students consider relevant to their future career. They reported that some participants felt that the IPE did not adequately represent their role or tasks, which made them feel that their profession was less important, and the perception that their profession was less valued may have had a negative impact on the professional identity of those participants (Kaldheim et al 2021).

Students in Whiting et al's (2016) study reported explaining their own roles during IPE resulting in a more positive perception and an increased pride in their own profession. Whiting et al (2016) suggested that learning with peers from other professions reinforced the feeling in the students that they had made the correct career. Lecturers involved in the same study also noted the 'professional pride' exhibited by the different groups of students. The students appreciated the opportunity to increase other professions understanding of what their profession does (Whiting et al, 2016). This strengthening of professional identity reported by the students resonates with the experiences reported by Allen et al (2014. However it is interesting that when comparing the studies, this similar

result emerged through different experiences. The participants in Whiting et al's (2013) study identified an increased professional identity as a result of explaining their own roles to students from other professions and through 'inclusion' with other groups, whereas those in Allen et al's (2014) study reported that as a result of having to attend additional lectures delivered specifically to their small group they developed a strengthening of their bond as students and the development of a shared professional identity, through what may be considered to be exclusion rather than inclusion.

Osman (2017) reported that the medical students in their felt that IPE enabled them to gain more of an awareness of their own role, as well as that of others. Interestingly Osman (2017) reported how the students described some tensions being apparent within the interprofessional teams involved in the IPE. The students suggested these were related to a lack of understanding caused by their different training objectives and standards, and that they might be reduced through regular interprofessional contact. Tran et al (2018) agree, reporting that students in their study had a lack of knowledge regarding the roles and responsibilities of other professions and would like to have had interprofessional learning activities. The students suggested that had they had the opportunity to learn more about each other, it would have increased their willingness to ask for help from the other professions in future. Interestingly, Tran et al (2018) found that students' focus on their own profession was perceived as an obstacle to IPE. They reported that students were pre-occupied with learning the responsibilities of their own profession and this may have affected their willingness to collaborate with students from other professions. Tran et al (2018) commented that the students believed that if there was an expectation and requirement for them to collaborate with other professions' students, it would have made it easier for them to change focus from their own profession.

Clancy et al (2020) have proposed that students become socialised into hospital cultures using pre-existing assumptions of professional stereotypes and hierarchies. This results in them gaining attitudes, values and behavioural norms of their profession and can create a professional social identity that favours those from their own profession (Clancy et al 2020 p 288). They suggest that IPE may counteract social and organisational challenges of power and professional identity that impact on IPW. Clancy et al's (2020) investigations suggested that there was a shift in the perceived difference in power between professional groups during the process of sharing experiences. They found that students changed their view of other professions as a result of engaging in the process and removed some of the 'barriers' between the different health professions. Clancy et al (2020) suggested that contact with individuals from professions that they may not normally come into contact within the placement environment supported participants to gain understanding of these

new roles potentially aiding IPW. They reported that their findings highlighted the role of IPE activities in humanising healthcare and promoting connection across professions through focusing on common humanity.

In support of this, O'Carroll et al (2016) had previously suggested that IPE interventions provided during undergraduate programmes were seen to positively influence attitudes to collaborative working. Qualified staff with experience of IPE felt more prepared for IPW and had increased self-awareness of positioning in a team, compared to those without prior IPE experience. Derbyshire and Machin (2011) acknowledged that the existence of negative professional stereotypes within the interprofessional team can be a barrier to effective IPW but proposed that IPE can help reduce negative stereotypes. They reported that participants' in their study suggested that their stereotypical views of other professions had changed positively as a result of their IPE experiences.

2.7 Communication and Teamwork

A number of the studies reviewed have highlighted the effect of IPE on communication and teamwork. Aase et al (2016) conducted a study exploring different professional perspectives of IPE for nursing and medical students in Norway. Through the use of focus groups, individual interviews and field observations of nursing and medical students, academic staff and hospital staff, they investigated perspectives regarding the design of IPE. All participants agreed that IPE should include mandatory practice in clear, concise and timely communication which they suggested is essential to ensure the delivery of quality medical care and treatment. With reference to communication supporting teamworking, Aase et al (2016) cited a doctor who participated in their study stating "let us not educate soloists but rather members of the orchestra" (Aase et al, 2016 p 111).

Roberts and Goodhand (2018) highlighted how students reported an increased awareness of the importance of good communication through engagement in IPE and how teamwork and respect were an essential component for effective IPW. They also reported on how students gave examples from the IPE activity where they felt poor interprofessional communication had influenced the effectiveness of their patient interactions, and as a result had learnt that communication could have an impact on improving the quality of patient care.

Domac et al (2015) conducted a narrative analysis of reflective IPE portfolios and interviews with medicine, social work, and speech and language therapy students. They reported evidence of developing communication skills and understanding the importance of advancing interprofessional communication. Kelley and Aston (2011) reported students developing an understanding of how effective communication and collaborative working contributes to better patient care. Students

commented on how IPE had made them more aware of the importance of good communication between members of the multi-disciplinary team, and how IPE encourages better communication between the different professions. Participants in Wright et al's (2012) study reported how their IPE shadowing experience had highlighted how crucial good communication is for successful team functioning and effective patient care.

Participants in Derbyshire and Machin's (2011) study reported that their ability to communicate with other professionals had improved as a result of their IPE and that through working in small interprofessional groups they came to realise that 'communication and teamwork are common to all professionals' (Derbyshire and Machin 2011 p 241). Kaldheim et al (2021) concluded that participation in the IPE activity had resulted in a building of greater mutual understanding and respect for each other as different professions working together. Participants learned how to communicate and work together in an interprofessional team, acquiring insights into each other's tasks and how best to prioritise those tasks. These findings agreed with Afseth and Paterson (2017) who had previously concluded that the interprofessional assessment examined in their study improved team working and appeared to help participants to develop an understanding of how another profession approaches the same skill.

2.8 Hierarchy and Power

Some authors have explored the influence of hierarchy and power between and within professions on IPE. Tran et al (2018) reported that students in their study had all experienced hierarchy among healthcare professionals, and believed that this hindered collaboration, communication, and shared knowledge. Tran et al (2018) suggested that students believed hierarchy made people feel 'too proud of themselves and prevented them from seeking help from other professions' (Tran et al 2018 p 5). They proposed that prejudices existed among all professions, however increased knowledge of other professions would help to prevent these prejudices and help to break down the hierarchy.

Telford and Senior (2017) suggested that the mix and power dynamics that exist within the range of health professions may also be significant in IPE interventions and that 'power struggles between groups' (Telford and Senior 2017 p 350) may negatively affect IPE. Students in their study commented on the dominance of adult nursing students in the IPE activity, and how this had impacted upon their IPE experience as the focus of the activity became very centred on adult nursing. Likewise, Stephens and Ormandy (2018) reported that students in their study felt that they benefitted more from IPE when there was a 'flat hierarchy' within the groups and that a sense of equality between all group members and facilitators was essential.

Clancy et al (2020) proposed that IPE may counteract social and organisational challenges of power and professional identity that impact on IPW, however they reported how fear of judgment from others associated with power and social acceptance had limited the engagement of some students in the Schwartz round IPE activity. Some students commented on how their status as a student in the presence of staff made them feel vulnerable due to the 'power that lecturers have' and resulted in them feeling reluctant to engage fully in the activity. However, others commenting on the shifting of power as a result of engagement and how the process had led to an equalising of the group. Clancy et al (2020) cited one participant who stated the IPE activity had "removed the barriers between the different health professions and different seniorities" (Clancy et al 2020 p 291).

O'Carroll et al (2016) suggested that professional identity, professional culture and inter professional hierarchies may influence attitudes to interprofessional education and IPW. They observed that perceptions of power may negatively impact on attitudes to IPE, suggesting that doctors were reported to be less engaged in IPE initiatives within the health care setting compared to nurses and allied health professionals, and that these negative attitudes to IPW were linked to a greater perception of their role as doctors as the main decision makers in the healthcare team.

Power relations between professionals emerged as a theme from Wright et al's (2012) study of interprofessional shadowing. They reported how students often seemed to expect to observe traditional professional hierarchies and power dynamics during their visit and seemed pleasantly surprised if this was not the case. Wright et al (2012) suggested that observations of complex and differing relationships between healthcare professionals will impact upon student attitudes towards other healthcare professions. They proposed that uncovering attitudes toward other healthcare professions and gaining an understanding that different professional groups will have different experiences of power structures are significant steps for students developing their own professional identity and relationships with others. They concluded that IPE learning opportunities for students is one way to start addressing these inherent phenomena (Wright et al 2012).

Leedham-Green et al (2019) analysed a random selection of formative essays submitted by second year medical students describing and reflecting on their experiences of how professionals worked together during their time on placements. They reported how students expressed insights into how hierarchy within professions and tribalism between professions are damaging to patient care and staff wellbeing. Students cited examples of consultants being observed to show a lack respect for trainee doctors, a junior team member feeling unable to call on their senior for support, clinicians keeping allied health professionals 'out of the loop' which they felt impacted on clinical care, and witnessing interprofessional and interpersonal micro-aggression, resentment and disrespect.

Students also reflected on the discrepancy between what is taught and what is practised, noting that teaching promotes respect, empathy and good communication. However, in practice they experienced miscommunication or no communication between certain disciplines within the hospital and practices such as the nurse and doctor blaming each other for errors. Interestingly the students also reported 'adversarial encounters' between nursing and medical students during campus-based interprofessional education. They commented on how tribalism between the professions extended into social relationships, with friendships tending to form within but not between professions. Conversely Leedham-Green et al (2019) suggested that students showed insight into how informal social communication and personal friendship mitigated against the adverse impacts of hierarchy or tribalism and students described wanting to emulate and spread interprofessional behaviours and practices that they had positively evaluated and to address the drivers of interprofessional tensions. Students expressed a desire to engage in positive change even after negative experiences. Leedham-Green et al (2019) concluded that the culture into which students are being socialised is one of contextual tensions driven by hierarchical and tribal social structures (Leedham-Green et al 2019 p 7) but that IPE experiences offer an opportunity for students to question and criticise practices where they deem them to be ineffective or suboptimal, and that they will identify with and aspire to emulate examples of good practice and positive relationships. In support of this Alsio et al (2019) concluded that an IPE intervention such as the introduction of students into a community of practice led to learning experiences among the staff and changes in the community of practice. Participants reported cultural changes within the hospital community and a reduction of hierarchies between different professionals by increasing their contact and interaction with each other.

Aase et al (2016) reported that many nursing students and supervisors in their study expressed concern over what they perceived as the doctors' dominating role in interprofessional collaboration. However, they observed the nursing students largely accepted the dominance. Aase et al (2016) stated that they found the power relationship between nurses and doctors to be balanced towards the doctors and that nurses refrained from voicing their concerns during interprofessional work.

2.9 Summary

Facilitation, awareness of others and self, communication and teamwork and hierarchy and power are themes that emerged from the literature. These have been critically explored and discussed in this chapter. The next chapter will discuss the methodology adopted for the study and discuss the method of data collection and analysis.

3.0 Chapter 3. Methodology

3.1 Introduction

There have been numerous studies to date which have considered IPE from the perspective of students, practitioners and educators. Approaches have been quantitative, qualitative and mixed methods. In 2010 Reeves et al (2010) argued that a key limitation then had been the limited use of qualitative methods that may provide insight into how IPE affects change. Qualitative data can give greater insight into a student's experience allowing participants to describe their personal experience in detail. In establishing that IPE has been successful, it is useful to understand how it influenced the attitudes and behaviour of participants.

Only two studies identified in the literature review have adopted an Interpretative Phenomenological Analysis (IPA) approach to explore the experiences of students engaging in an IPE programme. Clancy et al (2019) adopted an IPA approach to investigate the subjective experiences of mental health nursing, adult nursing, clinical psychology and medical students of Schwartz Rounds as an IPE initiative. Allen et al (2014) used IPA to investigate IPE and consider the experience of interprofessional education of students on a combined nursing and social work degree.

This research is an investigation into how pre-registration healthcare students experience interprofessional education (IPE). it was therefore important that the methodology was flexible and participant-oriented enough to allow the real 'lived experiences' of the participants to emerge. Smith et al (2012) state that "IPA is a qualitative research approach committed to the examination of how people make sense of their major life experiences" (Smith et al, 2012 p 1). IPA is seen by many as the most 'participant-oriented' qualitative research approach that shows respect and sensitivity to the 'lived experiences' of the research participants (Alase 2017). Alase (2017) further suggests that the intent of an IPA approach is to tell the true 'lived experience' stories of the participants, so that readers can say to themselves "I now have a better understanding of what it is like for someone to experience that" (Alase 2017 p 13). This is entirely in line with the aims of this proposed study and the same rationale for the choice of IPA as a methodological approach may therefore be offered. The aim of this chapter is to review IPA, provide a rationale for the choice of IPA as a methodology for the study and discuss the method of data collection and analysis.

3.2 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is a qualitative research process that allows a subjective exploration of an experience from a participants' perspective (Roberts 2013). Originally developed in psychology, IPA was pioneered by Jonathan Smith and is now increasingly used in other

disciplines including health, education and social sciences. The intention of IPA research is to explore how individuals make sense of their experiences. As Carpenter (2009) suggests IPA requires the researcher to attend to the participants' 'life world' and then develop interpretations which help to explain what it is like to be that person in a particular context. One of the fundamental principles of IPA is that only those who have experienced a phenomenon can communicate it (Roberts 2013). IPA offers a methodological approach to explore in depth how individuals experience and place meaning to a specific phenomenon (Clarke 2009). IPA considers the individual in a local context, but by capturing context specific situations, it allows broad-based knowledge to be contextualised within a social and cultural context, producing relevant findings (Charlick et al 2016).

IPA allows for multiple individuals who experience similar events to tell their stories and focusses on describing what all participants have in common as they experience a phenomenon. The most important benefit of IPA is its ability to make sense of the 'lived experiences' of people who have experienced similar phenomenon (Alase 2017). However, IPA is additionally concerned with participants' subjective experiences of the world and assumes that people can "experience" the same objective experience in different ways (Carpenter 2009). In this study, the aim is to investigate the way in which pre-registration healthcare students make sense of their experiences of IPE. Conducting a study with an IPA approach in this context was appealing because as an education researcher with a healthcare background, it satisfied my curiosity about people and provides an opportunity to explore and understand how individual students perceive and experience an educational approach from their own perspective.

3.2.1 The Theoretical Foundations of IPA as a Methodology

IPA has three primary influences; phenomenology, hermeneutics and idiography (Charlick et al 2016). Phenomenological research adopts one of two approaches; descriptive phenomenology and interpretive phenomenology and IPA has its origins in both of these. Descriptive Phenomenology is an approach developed by Edmund Husserl that attempts to enable a deep description of a lived experience (Roberts 2013).

Interpretive Phenomenology attempts to reveal and interpret the meaning embedded within an experience (Smith et al 2012). There is a recognition in IPA that researchers can observe and have empathy for the participants but can never share entirely the other's experience and can only ever see phenomenon from their own perspective (Smith et al 2012). Hermeneutics is the second major theoretical underpinning of IPA and is the theory of interpretation (Smith et al 2012). Hermeneutics originates in interpretation of biblical texts but has developed as a philosophical foundation of interpreting other documents and literature. Friedrich Schleiermacher, Martin Heidegger, and Hans-

Georg Gadamer are the three most important hermeneutic influences for IPA. Schleiermacher viewed interpretation as an art with elements of intuition, involving both grammatical and psychological interpretation (Charlick et al 2016). For IPA, analysis always involves interpretation, and making sense of what is being said or written involves close interpretative engagement on the part of the listener or reader. Heidegger suggested that the researcher brings their preconceptions to the encounter and cannot help but look at anything except in the light of their own prior experience. Despite this, the researcher will not necessarily be aware of all their preconceptions in advance of the reading and so reflective practices are required in IPA (Smith et al 2012). Gadamer, suggested that the researcher may only really get to know what his or her preconceptions are once the interpretation is underway (Smith et al 2012). Gadamer suggested that due to this complex relationship between the interpreter and the interpreted it is not possible to separate the researcher from the researched. The researcher can have a number of pre-conceptions and these are compared, contrasted, and modified as part of the sense-making process (Charlick et al 2016). Smith et al (2012) talks about considering 'what we bring to the text' in addition to 'what the text brings to us' – sometimes preconceptions can be identified in advance, sometimes they will emerge during the process of engaging with the phenomena presented. Either way this requires openness (Smith et al 2012). IPA acknowledges that any insights gained from analysis will necessarily be a product of the researcher's interpretation (Carpenter 2009). IPA is influenced by Gadamer and requires a reflexive attitude from the researcher. IPA aims to understand the participant's life world, but it also recognises that this is only possible through the researcher's engagement with, and interpretations of, their accounts (Carpenter 2009). Reflexivity is a process of cognitive self-awareness integral to IPA and was used in this study. It was intended to identify any preconceptions, biases or presumptions that the researcher may have had due to personal or professional experience which could affect the research. Given that the researcher is a senior lecturer within the same faculty as the students it was also used to explore the power relationship between the researcher and the participants.

The hermeneutic circle is important in the method of IPA and is concerned with the dynamic relationship between the part and the whole – to understand any part, one must consider the whole and to understand the whole, one must look at the parts (Smith et al 2012). It is a key principle of IPA that the process is iterative - that ways of thinking about the data move backwards and forwards rather than completing each step one after the other. As the researcher moves backwards and forwards through the process, their relationship with the data shifts according to the hermeneutic circle. Entry into the data can be made at a number of levels, all relating to each other, but many of which will offer different perspectives on the whole-part coherence (Smith et al 2012). Double

hermeneutics acknowledges that individuals will self-interpret events or phenomena, and Smith et al (2012) suggest that IPA uses a 'double hermeneutic circle' where the participant makes sense of the experience, but an additional process happens when the researcher makes sense for themselves of what the participant is saying.

Idiography is concerned with the particular and is the third major influence on IPA. IPA is concerned with the particular at two levels. Firstly, in the sense of detail and depth of analysis, which must be thorough and systematic. Secondly, with a sense of understanding how a particular experiential phenomenon has been understood from the perspective of particular people, in a particular context (Smith et al 2012). To achieve this, IPA studies utilise small, reasonably homogenous, purposively selected and carefully situated samples. Idiography does not avoid generalisations, but rather offers a different way of establishing those generalisations – the detail of the individual brings us closer to significant aspects of the general; "the particular and the general are not so distinct" (Smith et al 2012). Because IPA is ideographic and so concerned with an in-depth examination of the particular, sample sizes are usually small. When selecting the sample for a study following the IPA approach, it is essential that all participants have similar lived experience of the phenomenon being studied (Alase 2017) and that selection of these participants should reflect and represent the homogeneity that exists among the participants' sample pool. This study involved pre-registration healthcare students at the same university in two different year groups who have experienced IPE in different ways. The participants were selected purposively to allow insight into their experience. In line with the principles of IPA this allowed examination of convergence and divergence in some detail (Smith et al 2012). As with all IPA studies, numbers were small as the essence of an IPA research project is to get 'rich' and 'thick' descriptions of the 'lived experiences' of the research participants (Alase 2017).

3.2.2 Other Approaches

IPA may be compared to other qualitative approaches which seek to understand experiences of participants. Discourse analysis is focused on use of language, how language allows reality to be understood, and thus meaning to be created (Starks and Brown 2007). So discourse analysis has an inherent sensitivity to the language being used by the participant, which is less important than the hermeneutic, ideographic and contextual focus of IPA (Smith et al 2012), and therefore less applicable to the aims of this study. The rationales behind discourse analysis and IPA are different. Both are based on extracting detail from the participant's reports, but in IPA researchers talk to participants so that they can analyse what they are saying in order understand how the participant make sense of their experience, whereas discourse analysis focuses more on the process used by the

participant to construct accounts of their experience. Thus, discourse analysis was not considered as an approach for this research.

Likewise, grounded theory may be considered as an alternative to IPA. Grounded theory aims to develop a theory of social processes, studied in the environments in which they take place (Starks and Brown 2007). In grounded theory the researcher acts as a witness and presents an account of the social reality. There is a deliberate attempt to ensure their own preconceptions are not introduced into the research (Carpenter 2009). Grounded theory and IPA are similar in that they are both approaches which are inductive – information is gathered and conclusions are drawn from what is observed. However, it may ultimately be suggested that grounded theory attempts to develop a theoretical claim, whereas IPA aims to identify potentially broader issues from the analysis of individual accounts. Thus, grounded theory was not considered as an approach for this research.

3.3 The Research Question

According to Alase (2017), in a qualitative research study the research questions should encapsulate the essence of what the research study is trying to uncover - the ontological, epistemological and methodological stance of the research study. The research question is important in determining the direction of the literature review and methodology. During my research proposal I set out that I intended to evaluate IPE activities and developed an initial question of how do students evaluate their experiences of IPE. However there are many ways to evaluate IPE activities. Some authors have used quantitative methods to investigate IPE through the application of instruments or 'models'. The Readiness for Interprofessional Learning Scale (RIPLS) (Parsell & Bligh, 1999) is a Likert based self assessment tool and has been used to investigate the attitudes of students to IPE (Evans et al, 2012, Ritchie et al 2013, Colonio Salazar et al 2017). The Attitudes Toward Health Care Teams Scale has been used to assess student perceptions regarding IPE (Dominguez et al, 2015) and the Interdisciplinary Education Perception Scale (McFadyen et al, 2017, Sciascia et al, 2021) has been used to assess students' perceptions of interprofessional cooperation during an IPE programme. The results of these evaluations are presented as scores.

Although this type of research initially appealed to the technical side of the radiographer in me, I was conscious that, as previously explained, what was actually important to me was hearing from the students themselves about their experience rather than interpreting a metric - to hear the 'voice' of the students. Further review of the literature produced papers which aligned more closely with the main interest in this research which is the experience that students have of IPE explored from the view point of the individual involved. This is because they are best placed to describe and interpret their experiences. Thus the research question has evolved from 'How do students evaluate

their experiences of IPE' to "What are the experiences and perceptions of pre-registration healthcare students of interprofessional education". How people perceive their experience is influenced by a number of factors and therefore it is important to explore what these factors are and the effect they have on the experience.

IPA requires open research questions, focussing on people's experiences and/or understandings of a particular phenomenon in a particular context (Larkin and Thompson 2012). The intent is exploratory rather than explanatory which is in line with IPA's inductive processes and its attention on the interpretation of meaning (Smith et al 2012). So the research question in this proposed study "What are the experiences and perceptions of pre-registration healthcare students of interprofessional education" aligns comfortably with the epistemological position of IPA.

3.4 Theoretical Framework; Contact Theory

A number of theoretical frameworks have been proposed as a basis to investigate and evaluate IPE (Barr 2013), including those associated with adult learning (Knowles 1984), experiential learning (Kolb 1984) and reflective practice (Dewey, 1933 and Schon, 2016). Adult Learning Theory (Knowles 1984) is based on the premise that adults are independent and responsible for their own learning, that they use their experiences to contextualise their learning, that they focus their learning on their roles and responsibilities and that they learn best when applying concepts to their daily lives. With regard to IPE, the application of adult learning principles emphasises cooperative, collaborative, reflective and social constructed learning generated during exchange between the learners (Clark 2006, Clark 2009). Likewise Reflective Learning based on the work of Dewey (1933) and developed by Kolb (1984) and others supported the continual examination of beliefs, assumptions and hypotheses, turning practice into opportunities within which participants individually, in pairs or in groups, could learn, grow and develop. Schon (2016) distinguished between reflection-in-action (which happened immediately based on practice know-how) and reflection-on-action (which happened later taking into account guidance for practice).

Theories from social psychology, sociology and education have been identified as being significant to IPE including Situated Learning (Lave and Wenger 1991), Social Identity Theory (Tajfel and Turner (1986) and Contact Theory (Allport 1954) among others. Situated learning, as proposed by Lave and Wenger (1991) is based on the principle that learning is embedded within activity, context and culture as opposed to classroom learning that involves the acquisition of abstract knowledge which is and out of context. It is also argued that situated learning is usually unintentional rather than deliberate. According to Lave and Wegner (1991) Situated learning is integral to 'communities of practice' which are groups of people who share a craft or profession. It is more than learning by

doing or experiential learning. It involves people building their identity by negotiating the meaning of their experience to become full participants in their group. It makes the assumption that through engagement in groups, professionals learn and create an identity (Wenger 1998). Developed from work with apprenticeships, Lave and Wenger (1991) proposed the concept of 'legitimate peripheral participation'. This suggested that as individuals join an established group, they start on the periphery watching and learning how the group works and how they can participate. This is a social learning theory, based on the premise that learning is through social participation, a process in which people are not only active participants in the practice of the community but also through which they develop their own identities in relation to that community. Other researchers have further developed Situated Learning theory. Collins, Brown, & Newman (1988) proposed the idea of 'cognitive apprenticeship' and that that knowledge is acquired through activity and that the activity in which knowledge is developed should be an integral part of what is learnt. A community of practice exists because an activity occurs where a community of people are engaged in actions whose meanings are negotiated with each other. It is the negotiation of a joint enterprise that keeps people in communities of practice together (Wenger 1998). Participants may have different roles within a community of practice and mutual engagement involves complimentary contributions to the practice. This assumes that practice is commonly 'negotiated' towards a common aim, for example when practitioners from different professions work together as a team to provide care and treatment for one patient. Wenger (1998) discussed boundaries in relation to communities of practice. These boundaries are permeable and changeable. This has implications for IPE. Individual professionals traditionally trained and mainly practiced independently; communities of practice have developed closed boundaries around a specific professional group. This resulted in a reduction in the ability to learn from other professionals and deterred communication between professional groups. IPE aims to foster collaboration between professional through learning and working together, and encouraging the formation of interprofessional communities of practice with permeable boundaries. A community of practice with permeable boundaries will welcome ideas from anyone, no matter what their profession, and there will be shared learning and development between the members of the group.

Social Identity Theory developed by Tajfel and Turner (1986) proposes a difference between personal and social identity and argues this underpins the difference between interpersonal situations and group situations. Behaviour in interpersonal situations is governed by the individual whereas behaviour in group situations is governed by the expectations of the group. The premise is that individuals derive their identity from membership of social groups and that they prefer to have a positive rather than a negative identity, thus viewing the 'in-group' more positively than the 'out-

group'. Social Identity Theory would emphasise a group-based rather than individualistic approach to achieving integration and collaboration, which would suggest that individuals from specific professional groups could categorise themselves with others from another professional group under a 'common' group – for example OTs and physiotherapists seeing themselves as Allied Health Professionals, but this new identity is only likely to be accepted if it seen to be more valued than the individual professional identity (Carpenter and Dickinson 2016).

Situated learning is a social learning theory and as such involves the formation of identity (Wenger 1998). Communities of practice may be considered to be groups, and people belong to many groups and membership of one group will form only part of their identity (Wenger 1998). Wenger (1998) suggested that identity is formed through experience and participation in groups and argued that we constantly re-evaluate through our lives. Lave and Wenger (1991) acknowledged that the prospect of individuals being welcomed into a group, becoming full members and knowledgeable practitioners is challenged by the fact that conditions can exist in groups that are barriers to such development. They identified poor relations with seniors as being amongst such adverse conditions. Wenger (1998) proposed that established power relationships and a strong prevalent hierarchy can keep new entrants on the periphery of the group or community and thus be a barrier to learning through participation

Carpenter and Dickinson (2016) reported 'generalisation beyond the immediate contact situation' is crucial if a positive attitude change to another professional group as a result of contact with individuals from that professional group is to occur. Brown (2000) identified models to achieve generalisation which were all forms of 'contact hypothesis' and all based upon Social Identity Theory.

The 'contact hypothesis', also known as Contact Theory, was first proposed by Allport (1954), who suggested that positive effects of intergroup contact occur in contact situations. In his 'contact hypothesis', Allport (1954) suggested that prejudice and hostility between groups could be reduced by bringing members of the different groups together, although it was acknowledged that contact on its own would not be enough to produce attitude change and there were conditions that were required to support the contact. These conditions were deemed to be equal status, intergroup cooperation, common goals, and support by social and institutional authorities (Allport 1954). Since Allport's original work, four additional factors have been identified as crucial by Hewstone and Brown (1986); participants in the contact need to have positive expectations; the joint work needs to have a successful outcome, there needs to be a focus on both similarities and differences between members of the groups; and conflicting group members need to perceive each other to be 'typical'

members of the other group (the 'out-group') (Hewstone and Brown, 1986). Hewstone and Brown (1986) also proposed that stereotyping played an important role, whereby 'other' individuals are categorised by a characteristic such as gender, race, or perhaps professional uniform and a set of attributes is then ascribed to members of that category. Members of that category are then assumed to be similar to each other and different from other groups. Therefore 'out-groups' (those groups of which individuals are not members) are generally seen as homogeneous while the 'in-group' (groups to which individuals perceive themselves to belong to) is seen as more diverse.

A number of authors have identified Allport's Contact Theory as one of the key theoretical perspectives on IPE and have applied contact theory to the evaluation and analysis of IPE activities (Barr 2013; Carpenter and Dickinson 2016; and Thistlethwaite 2012) and have highlighted the importance of conditions for positive attitude change required by contact theory as identified by Allport (1954) and Hewstone and Brown (1986). Mohaupt et al (2012) proposed that contact theory is a useful theoretical framework for IPE as it addresses the concepts of stereotypes, social groups and hierarchy. Experiences of IPE can thus be investigated using the lens of intergroup contact theory. This research explored the way in which pre-registration healthcare students experience IPE with a particular focus on the themes which emerged from the literature review - facilitation, awareness of others and self, communication, teamwork and hierarchy and power. The research question to be answered is 'What are the experiences and perceptions of pre-registration healthcare students of interprofessional education?' and this was considered through the theoretical lens of contact theory.

3.5 Method

This study involves two cohorts of pre-registration healthcare students at the same university but in two different year groups who have all experienced IPE. The two different year groups have had IPE delivered in different ways.

In the 2012 programme followed by those students in the A17 cohort, students study one Collaborative Practice (CP) module per year and one Professional Development (PD) module per year. The other four modules are pathway specific. The collaborative practice modules – CP 1, 2 and 3 are delivered in interprofessional event weeks and in seminars throughout the year. There are two interprofessional, or CP, weeks each year with two day-long seminars each year. Students are allocated to a group with students from other professional groups. The CP seminars are led by a member of faculty staff who may or may not be of the same profession as the students in their group.

In the 2017 programme, followed by students in the S17 cohort, there are no core CP modules. Rather the emphasis is on the separate, individual programmes embedding IPE into the curriculum delivery in both theoretical modules and practice, with a greater emphasis on linking the theoretical learning to IPE experiences in the practice environment. Students are provided with opportunities, through the provision of 'core' IPE days, to engage in classroom-based IPE activities as an essential component of their programme.

Participants were recruited by a notice being placed on the cohort Blackboards asking for volunteers to participate in the study. Students who expressed an interest in the study were contacted by the researcher with further information, including the participant information sheet (Appendix 2). From those students who volunteered to participate, two were randomly selected from each cohort. Semi-structured interviews were held with the four selected participants who consented to participation in the study (Appendix 3). Each participant was identified by a pseudonym. Meg was a Midwifery student and Jo was an Occupational Therapy (OT) student and were in the A17 cohort following the 2012 programme. Beth was a Midwifery student and Amy was an Adult Nursing student and were in the S17 cohort following the 2017 programme. The interviews used open-ended questions to facilitate a guided conversation (Appendix 4). The interviews took place on the university campus and each participant was interviewed twice. Participants were asked about their availability prior to the interviews to arrange a mutually convenient location and time. The first interviews took place in June and July 2019. The second interviews took place eight months after the first interview in February and March 2020. Emerging themes were explored with the researcher considering and reflecting on his own interpretation.

IPA is best suited to a data collection method which allows participants to offer a detailed first-person account of their experiences, and interviews enable the expression of thoughts and feelings about the phenomena under investigation (Smith et al 2012). But IPA also requires that participants are permitted to tell their stories, to speak freely and reflectively and to express their ideas and concerns in depth and at length (Smith et al 2012). Semi-structured, one-to-one interviews are the preferred means for collecting such data allowing a rapport to be developed and giving participants time and space to think, speak and be heard (Reid et al 2005). Interviewing allows the researcher and participant to engage in a dialogue whereby initial questions are altered in reaction to participant's responses, and the researcher can delve deeper into any interesting areas which arise. The interview schedule was developed based on the interview guide used with focus groups by Telford and Senior (2017) which set a provisional agenda of topics to be discussed with the participant (Appendix 3). Interviews were recorded and transcribed. Transcripts were analysed, and

emerging themes were examined with the researcher considering and reflecting on his own interpretation.

The procedure adopted for this study is that recommended by Smith et al (2012) and is designed to allow a reflective consideration of what the participant is saying. As Smith et al (2012) observe, although IPA is primarily concerned with the lived experience of the participant and the meaning they make of that lived experience, how the analyst interprets that thinking is always the product of the investigation.

The first interviews were considered together, and then the second interviews were considered together. Each individual interview was treated as an individual case and followed the same process. The transcript was read several times and viewed alongside listening to the recording. With each reading the researcher can expect to become more immersed in the data. The second stage involved noting anything of interest in the transcript, examining content and language use. This enabled a developing familiarity with the transcript and began to explore the ways the participant talked about, thinks about and understands specific issues. This process produced a detailed set of notes and comments on the transcript. As suggested by Smith et al (2012) exploratory comments and notes were made using three different processes and foci:

- Descriptive Comments – These focussed on describing the content of what the participant has said. Key words and phrases are recorded with the aim of highlighting what makes up the participants thoughts and experiences.

- Linguistic Comments – These focussed on exploring the specific use of language and how the content and meaning were presented in the transcript. Matters such as metaphor were considered as well as use of pauses, laughter, tone, emphasis and repetition

- Conceptual comments – These focussed on engaging at a more interrogational, interpretive level with the analyst posing questions about some deeper meaning of the content of the transcript which are to be considered and explored (Smith et al 2012)

The third stage involved the development of emergent themes. This part of the process entailed moving away from direct interaction with the transcript and working primarily with the notes and comments made during the previous stage. Turning notes into themes meant producing a statement of what seemed to be important in the comments and notes made from the transcript. It was intended that emergent themes would capture and reflect an understanding.

The fourth stage was to identify super-ordinate themes by identifying patterns between emergent themes. The two processes of ‘Abstraction’ and ‘Subsumption’ as recommended by Smith et al

(2012) were employed to put 'like with like' and bring together a series of related themes. An example of the process can be in Appendix 5.

The fifth stage involved moving to the next participant's interview transcript and repeating the process. This involved an element of bracketing the ideas emerging from the analysis of the previous transcript(s) in line with the idiographic commitment of IPA. New themes were looked for and allowed to emerge as well as themes which had emerged from the analysis of the previous transcript(s) This then continued for each of the four participant interviews.

The final stage involved looking for patterns across transcripts and considering what connections there were between the participant interviews and which themes were most prevalent and common to participants. In this way it was possible to identify themes for the group of participants and if there were any themes nested within superordinate themes. It was important to take a reflexive stance and acknowledge any influence the researcher may have on the interpretation of the data. After each interview had been analysed as an individual case, comparisons were made with the other interviews undertaken at the same stage.

As part of the hermeneutic circle, once all the data had been collected a longitudinal analysis of each individual participant was undertaken. Finally, areas of commonality and/or divergence between the two sets of interviews were identified and examined. The whole iterative process helped to refine the researcher's understanding and interpretation yet kept it grounded in the participants' own interpretation of their experience which is the essence of double hermeneutics.

3.6 Ethical Considerations

Ethical approval was obtained from the university for this research study to be conducted (Appendix 6). Participation was entirely voluntary. Informed consent was obtained from all participants (Appendix 2) and confidentiality and anonymity of the participants was ensured throughout the research process. Names of each participant were changed to preserve anonymity. The research project did not involve invasive or intrusive procedures or cause stress or anxiety to participants. However, it is acknowledged that these participants were students on pre-registration programmes within the Faculty of Medicine, Health and Social Care and the researcher is a member of the academic staff within the Faculty. There is therefore the risk that students may have felt pressured into participating and that there may be an unintended, hidden issue of power imbalance between the participant and researcher. In acknowledgement of this, and in an attempt to avoid this situation, students were not asked individually to participate, where they might have felt an obligation. Rather, a notice was placed on the cohort Blackboards asking for volunteers to

participate in the study. Students who expressed an interest in the study were contacted by the researcher with further information, including the participant information sheet. Students were reassured that participation was entirely voluntary and that the decision to participate or not had no bearing on their course marks or assessment. It has already been acknowledged that the researcher is a lecturer on the Diagnostic Radiography programme and because of this, students on the BSc Diagnostic Radiography course were not included in the request to participate in the study.

From those students who volunteered to participate, two participants were randomly selected from each cohort. These participants were asked about their availability prior to the interviews to arrange a mutually convenient location and time and subsequently these details were confirmed either by telephone or email. In line with good ethical practice, participants were provided with an information sheet detailing the aims of the study, the requirements of them as participants and their right to withdraw from the study at any time without the need for providing a reason. Informed consent was obtained and documented prior to data collection. Each interview was recorded and transcribed verbatim. Once the researcher had checked that the recording and the transcript were the same, the recording was erased. Each participant was given a pseudonym and identifying details were removed from any transcript and were not included in any final report and/or any publication to make it impossible to identify any participants.

3.7 Summary

In this chapter the decision to adopt IPA as the research methodology was thoroughly explored. The research process and research methods were explained, including participant recruitment, the interview process and ethical considerations. The next two chapters present the results from Interview 1 and Interview 2 from this study.

4.0 Chapter 4. Results; Interview 1

4.1 Introduction

This chapter presents the results from Interview 1 from this study. Through the implicit nature of IPA, the results reflect the thoughts, comments of the participants and the interpretation of those by the researcher. Direct quotes from the participant interview make up a great deal of this chapter together with analytical comments in line with the concept that the interpretation is grounded in the data (Smith et al 2012). The use of dots (….) in the quotations indicates where extraction of less relevant words has occurred during editing. For the clarity of the reader, the two students who followed the 2012 curriculum (Meg and Jo) have been annotated as Meg[1] and Jo[1] and the two students who followed the 2017 curriculum (Amy and Beth) have been annotated as Amy[2] and Beth[2]. The results are presented without reference to existing literature and separate to the analysis and discussion.

4.2 Contextualising IPE

It is important to note what the participants contextualised as IPE. Although an initial reaction from some was to identify with IPE as being the formal classroom based, organised sessions as part of their taught curriculum:

"We have had, well, I have had an IPE day that was solely focused on interprofessional education"

Amy[2]*; Interview 1*

"I've had two years of collaborative practice as we call it, where our cohort of midwives is mixed with student nurses"

Meg[1]*; Interview 1*

Others immediately were of the view that they had experienced IPE both in the classroom and on placement.

"I think we've had different types. We've had structured ones at university. But you get learning experiences don't you on placement."

Beth[2]; Interview 1

However in the course of the interviews, and in recounting their experiences, all of the participants often referred to IPE happening in a variety of settings such as in the classroom and on placement, and did not seem to differentiate IPE as something that happened in a particular setting, or something that was either formal or informal. In the case of placement they associated IPE as working with both qualified staff and students from their own and other professional groups.

The analysis of the first interviews produced the super-ordinate themes of 'Learning from or about others', 'Hierarchy and Status', and 'Facilitation' together with some lower level themes. There were some additional issues that could not be considered to be themes as only one participant identified them, however they were sufficiently strong elements in the individual transcripts to warrant inclusion.

4.3 Learning from or about others

Learning from or about others came through as a strong theme in their experience of IPE for almost all the participants. There seemed to be a consensus that learning and understanding what other health care professionals did, and what their roles entailed was one of the fundamental purposes of IPE. The participants felt that there was benefit in having a knowledge and understanding of the roles of those that they did, or were going to be working with. But likewise, the participants felt that they benefitted if others had an awareness and an insight into their roles. It was apparent that the participants felt that IPE had a function in addressing issues of stereotyping, prejudice and breaking down barriers between professions. The concept of just having contact with individuals from other professions also seemed to be important. These issues will be discussed individually:

4.3.1 Roles

The concept of IPE enabling an understanding of the roles of others was clearly important to the participants. Meg[1] explained that she thought this was one of the fundamental purposes of IPE;

"learning about what other people do, understanding what they do, respecting what they do"
Meg[1]*; Interview 1*

And Jo[1] agreed that it was about learning about the roles of others;

"learning as well what other people do. And… what they do."
Jo[1]*; Interview 1*

Beth[2] talked about how her experience of IPE had allowed her an insight into the role of others;

"we got to learn about, you know, the roles that these people do."
Beth[2]*; Interview 1*

Conversely Jo[1] explained that from her experience of IPE, whilst she was able to inform others about her role, she got little from others in return;

"But, yeah, a lot of a lot of people don't understand our role. So that was quite good to share that. But we didn't really get the same...the same back..
Jo[1]*; Interview 1*

And she felt that there was not enough opportunity to share information with the group she was in during her IPE day;

"At the beginning, we was asked to sort of say what we did and the class. Oh, do you know what this person, what that person does... But I don't think enough time was spent on the different roles that were in our lecture group at the time... And so maybe a little bit more on the roles that make up the interprofessional learning course that you're on.."

Jo[1]*; Interview 1*

Similarly, Meg[1] was of the opinion that an understanding of the roles of others had only been achieved to a limited extent. She felt that the important criteria was the understanding of the roles of those professions that she was going to be directly working with presently as a student, and in the future as a qualified midwife. She explained that she felt much of her experience of IPE in the formal classroom setting had been with students from other professional groups with whom she had, or was likely to have little or no professional interaction;

"Thinking back, I think maybe something like year one, it was, um, we were sort, in one of our lectures we were sort of put in groups and told to go and research these different professionals and we came back and we said, look, this is what this person does...daa dee daa, But again, most of the people was radiographers.. and again as midwives we don't have a lot to do with radiographers.. sonographers yes, but not so much radiographers and I suppose maybe some of the people we were looking at it felt a bit irrelevant."

Meg[1]*; Interview 1*

"we as professionals, midwives, we don't really have anything to do with nurses, that's not... we don't really work alongside them. We don't work with them"

Meg[1]*; Interview 1*

Meg[1] seemed to express frustration that the people she had been asked to work with in the classroom IPE sessions were not from professions that she deemed to be more relevant to her;

"So it kind of feels to me a bit of an unusual mix for us to be with nurses rather than.. ..other professionals... I suppose like Doctors, obstetricians and gynaecologists people like that… those are the people that I suppose when I started I expected to be working with in terms of collaborative practice."

Meg[1]*; Interview 1*

In particular Meg[1] seemed to suggest that this was something that was a required part of the programme, and the need to have been seen to have 'done' this in the programme took precedent over the relevance of the process itself;

"it just felt like it was a thing to be ticked off the list. Oh, we need to do it. We need to show that we've learned about other people and we can tick it off the list"

Meg[1]*; Interview 1*

Although she acknowledged that the process of learning about the roles of others was useful, the 'value' of the experience of an insight into the roles of others seemed to be closely linked to this 'relevance' to her and her chosen profession;

"I suppose to a certain degree, yes, that can be done with nurses because, just because perhaps we're not going to work together in the long run doesn't mean you can't, sort of do that process now. But I guess for the future, for when you're qualified actually working with those people in that field, it would be more valuable, because your understanding more of what their role is and their experiences."

Meg[1]*; Interview 1*

Beth[2] had a different view of her experience of IPE and the people she had engaged with during her IPE activity;

"I really enjoyed it, because they are people that we will come across in our.. in our jobs. Hopefully jobs .... we will see nurses and we will see paramedics…. So we will see these people. We'll be working with them."

Beth[2]*; Interview 1*

Beth[2] and Meg[1] are in different cohorts. Meg[1] is in the A17 cohort and Beth[2] is in the S17 cohort. The difference in delivery of the respective programmes will have impacted on the experience of IPE by the participants and may contribute to the variance in views expressed.

The concept that IPE providing a facility to allow an insight into the experiences of others emerged quite frequently. The idea of a realisation that other students and health professionals face challenges, both different and similar, seemed to suggest a common ground that could allow individuals from different professions to compare and see something of themselves in each other;

"I'd never had a chance to sit down with a student nurse and find out their hours and their shifts, or an ODP and find out, you know, do you go out on placement?... How do you learn, how do they grade you, and I found that really helpful because you kind of get an appreciation for what they're going through"

Beth[2]*; Interview 1*

"I think it's just an appreciation for other people's workload that you get when you're having authentic conversations like that"

Beth[2]*; Interview 1*

"And I think little things like that makes me understand the challenges that she's got."

Meg[1]*; Interview 1*

In line with this enhanced awareness of the challenges faced by others, there was a frequent referral to the 'journey' taken by others amongst the participants and a mutual appreciation of this;

"..to say, Hi, I'm an SHO, this is what I do, this is my journey, this is where I'm going to get to, you know, and I suppose all that, so we can understand what their roles are and things and how we work together"

Meg[1]*; Interview 1*

"I think it was really.. It was nice just to have a conversation and to appreciate the journey that everybody else is on."

Beth[2]*; Interview 1*

"..'cos I think you can kind of learn a lot from an understanding of where people coming from, when you know, what their journey has been. And you know, you know, sort of difficulties that they have to overcome, the same as we're having to do through our journey as well."

Meg[1]*; Interview 1*

"It's not just us, like we think, our course is hard but theirs is too, and, you know, we're all on the same journey, essentially"

Beth[2]*; Interview 1*

It was not just learning about others and the roles of other healthcare professionals and students which was highlighted by the participants. It seemed equally important to the participants that IPE offered opportunities for others to learn about the participants' own roles and professions.

"OT was the one that people didn't really have a great idea of the role that we do. So from that point of view, they did. I would have thought they gained quite a lot of that."

Jo[1]*; Interview 1*

"And I think it works both ways. It's not just about, you know, them understanding me, again, it's about me understanding them and what they do and how they make the decisions or whatever.."

Meg[1]*; interview 1*

For Amy[2], in particular, learning about and from others was not so much defined by roles, but more about viewpoints and perspectives of others.

"If in like a health professional setting, I think its probably trying to get people...maybe like think outside the box. Not to just keep your... the views limited to what you know … It's always good to go out and look at other things and listen to other people's point of views and do more research and, you know, quick discussion and that it makes you aware .. or maybe trying to make you aware .... What I got from it was that it tries to make you aware of the things that you do.... That other people may be in the same environment do as well, but do differently"

Amy[2]*; Interview 1*

The concept that emerged from Amy[2] was that working with others in IPE enhances the observation that different people do things differently, and that there is not necessarily a right way or a wrong way of doing things:

"But you still get to the same place. You just have your own way of doing things, and other people have their way of doing things"

Amy[2]*; Interview 1*

"And then the way we work is different, you know, the way that someone might give an injection is different to the way someone else gives it. It still does the same job, you know, the outcome is the same, but it's done in a different way...."

Amy[2]*; Interview 1*

Amy[2] explained that through this heightened awareness of the perspective and views of others, IPE encouraged a more understanding approach to others and a reduced propensity to judge:

"it made me be realise instead of me judging people and backing off, to try and engage them a bit more because they might just not be aware of the things that they're doing."

Amy[2]*; Interview 1*

4.3.2 Breaking down barriers

It seemed to emerge that the participants felt that IPE had a function in addressing issues of stereotyping, prejudice and breaking down barriers between professions.

And I guess if people knew what your job was and knew something of what you've been through, there would be less of a them and us. It would be more just us.

Beth[2] *Interview 1*

"…learning together then breaks down those .. those hierarchies and prejudices.."

Beth[2] *Interview 1*

"I think if you have a better understanding of where each other is coming from, I think you have the potential to be able to communicate better and help to respect where each other is coming from a little bit more"

Meg[1]*; Interview 1*

"making me work with other people that I don't normally work with, because when you are … put in a group, you always tend to go to the people that you always work with. So you're never aware, of maybe other things that you're maybe even capable of doing or achieving because you're always in that comfort zone."

Amy[2]*; Interview 1*

The participants acknowledged that this breaking down of barriers had multiple benefits. The idea that outcomes could be improved – for service users and individual professions emerged:

"We all want the same things…. as long as we can all do our jobs and work well together, we all want to go to bed at night knowing that we've done the best we can and worked to the best that we can, and, and that was the real kind of theme, running through all of the education."

Beth[2]*; Interview 1*

"respecting and understanding how we work together to achieve best outcomes"

Meg[1]*; Interview 1*

"different setting, different pathways or different professions, but all with the same goal. And I think that's what really draws … it all together, that needs to be highlighted more, the fact that it is the common goals. That's why…it all exists, really"

Jo[1]*; Interview 1*

For Beth[2], she perceived the benefit of improved outcomes to come from the improved sense of 'teams' that IPE could encourage:

"you get more cohesive teams and better outcomes for women and staff, and less burnout and you're sharing the burden and appreciating each other a bit more."

Beth[2]*; Interview 1*

"I think there's trust there that we work together. And when things go bad, we're in it together."

Beth[2]*; Interview 1*

Beth[2] also recognised that IPE had helped to improve her own abilities to work in a team, and also to change her perceptions of others:

"I think I'm learning how to be a better team player, I guess"

Beth[2]*; Interview 1*

"I think my own perceptions have changed a little bit - Not I like to admit that I had preconceived ideas"

Beth[2]*; Interview 1*

Likewise, Jo[1] recognised that IPE could play a role in understanding the value of shared goals and outcomes:

"one thing I have learned is that regardless of anybody's attitude or opinion about another pathway, we all have the same goal, which is ultimately to help or improve somebody's life"

Jo[1]*; Interview 1*

Jo[1] was also in agreement that perceptions of others can be changed through IPE, by citing an example of classroom work with students from other professions where although she experienced some negative reactions from some students from another professional group, interactions with others from that same professional group were more positive:

"you get opinions over the years when you make your own opinions of people, different, different pathways … and regardless of what I said about the fact the paramedics really did look down on us, there was one or two paramedics that I sat there laughing with. So, it's not, everybody's not the same. I think that's the biggest thing to come from it is that you can't put any two people in the same bracket. Everybody is different. And it's about learning how to come together and be successful"

Jo[1]*; Interview 1*

Some participants did not think that their perceptions of others was based on any pre-conceived view of other professional groups, or that they had been encouraged to perceive individuals from other professional groups in any particular way. They felt that their view of others was not based on anything more than their own personal interactions with other individuals:

"I don't think I've been encouraged to feel one way or another about different groups of people. I think people have earned their own... I don't know what the word is .. their own title ... from my experience of them"

Meg[1]*; Interview 1*

"I think my opinions are based on my experiences, definitely. And those have been good and bad."

Meg[1]*; Interview 1*

"…all it did was it just made me feel a particular way about a particular person. I don't think I have a sweeping..opinion about, you know, all anaesthetists."

Meg[1]*; Interview 1*

4.3.3 Contact

The concept of having contact with students and professionals from different groups, and how that contact with individuals affects how members of other professional groups may be perceived and the impact on working relationships, emerged as something that was important.

Meg[1] recounted an experience with a doctor – a Senior House Officer (SHO) – where they had struck up an informal conversation:

"because we've worked together, we've had this conversation and she's learnt a bit about me and I learnt a bit about her, you know, I just thought moving forward that might be the difference"

Meg[1]*; Interview 1*

She explained that she thought by having had this conversation, having had an interaction that was on a social level in addition to being a professional level, and having found she liked her….

"she was really lovely and we were having a chat... we had quite a nice little chat"

Meg[1]*; Interview 1*

…Meg[1] felt that this may affect how she might interact with other SHOs in the future simply due to the fact that this conversation with an SHO gave her an insight into what SHOs do and the challenges they face:

And then when you come across a new SHO, you think OK, this is, I know this is what they do and this is how they do it. And actually, they might need a little support from me, even though I'm a student midwife and their going to be above me, actually, maybe I can help them

Meg[1]*; Interview 1*

It was also apparent that she felt the development of understanding may work in reverse and that contact such as this, or through other IPE opportunities could benefit students from different professions coming into contact with each other:

I think if your.. perhaps a student doctor and you … you meet up with other student midwives, again, it's that thing about learning about each other, learning about their learning experiences and what they have to do to get to where they are..

Meg[1]*; Interview 1*

Meg[1] also raised the issue that contact with students and qualified staff from other professional groups 'humanised' other people which would benefit working relationships:

"Yeah, these are midwives. Yeah, these are the doctors but actually they're actually people too, and they have lives, and family and commitments and all this other stuff. And it's not just all about being at work. You forget that don't you"

Meg[1]*; Interview 1*

Likewise, Beth[2] was of the opinion that having personal connections amongst healthcare professionals ultimately benefitted the service users. Talking about an upcoming multi-disciiplinary case meeting she was due to attend she suggested:

"it's nice to know, kind of, their backgrounds and maybe where they've come from and what they deal with and to have conversations that then create safety for this lady."

Beth[2]*; Interview 1*

And more generally in terms of benefitting teamwork:

"like the familiarity, the friendliness that warmth that teams get, I think that would definitely be impacted if you hadn't met somebody before or had any understanding of what they're doing, because it can be quite intimidating can't it to go into a situation where you don't know anybody."

Beth[2]*; Interview 1*

"I think it's so easy to stop thinking of everybody else as people. I think sometimes we isolate ourselves and it's nice to see.... nice to bring that together... And enforce that you are a TEAM, everybody, rather than we are a team of midwifes, or a team or whatever knowing the sort of people you're going to be working with, is beneficial"

Beth[2]*; Interview 1*

For Beth[2] having, just generally having contact with others during IPE sessions and hearing about their profession from them was something she found to be a very positive experience personally:

"I learnt a lot just from those conversations with the other people. And I think that make a big difference."

Beth[2]*; Interview 1*

"to hear them training and their passions was quite like, wow, you know, that's that's amazing. It's amazing that you feel that way about that. And to see their passion, then kind of gives everybody else a bit more respect for it, I think"

Beth[2]*; Interview 1*

For Amy[2], the personal benefits she reported from the IPE sessions were also related to personal development. She suggested that the interaction with other people from other professional groups, that she would not normally have interacted with led to a developing of her own self-awareness, particularly in terms of her own behaviours and how others may perceive her:

"I think for me it was more like the personal, on the personal level. Making me more aware of my weaknesses."

Amy[2]*; Interview 1*

"I have had an IPE day that was solely focused on interprofessional education, and it was, erm in a way it made me realise something about myself, that I was, that may be I would have just, not thought about in the day to day things that I do"

Amy[2]*; Interview 1*

Reflecting on a group activity that she participated on during an IPE day:

"... it was in the group and we're doing some work…. So I had this idea of the app when you were in the group.... So I kept going and going and going about all these ideas that I had.... And then everyone was quiet... And then it was like I was taking over. But it's not that I wanted to take over and I didn't want the input of other students. It was more of I had this idea and I just want to let it all out as much as I can before I forgot. And Jess, one of the students… said to me 'Oh did you actually

realize you've done everything and we haven't done anything, so what we gonna do? And then I was like 'Oh my god yeah! And then it made me reflect on some, like, maybe when I've done group work with when it was a presentation in class and, erm, I have done that as well. Maybe I've said to people, like, you're doing this and you're doing this and you're doing this. I've not actually made them, like, choose what they want to do."

Amy[2]*; Interview 1*

This realisation and understanding of her behaviour seemed to be quite a profound learning experience for Amy[2]. She expressed how the realisation initially created some quite negative emotions in her, but having had conversations with her mentor, she managed to turn these into positives and has consciously made efforts to change her behaviour:

"I literally then just thought, oh God, this is a weakness of mine. And I just made it like this bad thing and it brought me down a little bit … even when I interacted with my friends, sometimes I would… just be having a normal conversation, but I would, just, after that, I'll just, like, step back and it'll be 'cos I thought ' Oh do I always, you know, take over the conversations… And then it was just I thought oh god, yeah I should just keep my mouth shut a little bit. So yeah, but I did .... after my mentor said to me, like, don't make it into a negative thing, it is a positive thing that you have this amazing idea .. Or that you always, you know, are sociopath then and you interact with others. So keep that side of you. That's good. But then for you to turn that thing that you think is a weakness as well, just put some things or suggestions or let others speak first and then you speak after someone else has said anything and then just see how the conversation carries on. And I thought OK, And I've been doing that... it's been working… it's all changed for the positive"

Amy[2]*; Interview 1*

4.3.4 Race and Diversity

For Amy[2], IPE offered the potential for students to learn from and about each other in the areas of race and cultural differences:

"So I would like that to, not just for me and the other BME students to be, to learn from each other, but for the, let's say the white students as well, to be aware of some of the things that... not that we would like to change or we would like, you know,for them to understand. But it's just for them to get a bit more understanding. But then it then leads to the whole interprofessional thing that, you know, is your... we're at university and we're all different. But even if you go into a workplace, we're still different. But then if we learn that from the ground routes, which is like when at university, and then I feel like they would, like, help us more when go out into the big world out there."

Amy[2]*; Interview 1*

"I think, like, physically we are different, the colour, the race, we're all different, that way.... And as well, I feel like, the way we think. Is different, in a positive way I think we all have different thoughts ... And our thoughts are affected by maybe life experiences, and our daily, you know, day to day lives, and I feel like it would be good for us to just become aware of ... maybe more aware of each other. We are students but we are more than students. There's more to us than just being a student here."

Amy[2]*; Interview 1*

4.4 Hierarchy and Status

For all of the participants, hierarchy and status emerged as a strong issue from their experiences. When prompted to consider 'Do you think hierarchy between health professionals exists?' Meg[1] responded with a short answer accompanied by laughter, as if it was inconceivable to consider any other answer:

"Yeah! Massive hierarchy – there's hierarchy across the whole entire way!"

Meg[1]*; Interview 1*

Amy[2] and Jo[1] responded likewise:

"Of course. Yeah, of course."

Amy[2]*; Interview 1*

"There is hierarchy. Yes. Without a shadow of a doubt.."

Jo[1]*; Interview 1*

Although Jo[1] felt it was perhaps not common to all settings:

"Oh, I don't think it is across the board. but I think yeah you come across it definitely..."

Jo[1]*; Interview 1*

To the same question, Beth[2] responded similarly, but conceded that the concept was not necessarily a negative thing

I think to some extent there needs to be. I think it helps the teams run well… I think it's quite helpful because everybody's got their own limits of practice."

Beth[2]*; Interview 1*

Meg[1] however thought hierarchy could lead to some negative inter-personal relationships:

"And... there is hierarchy and sometimes people in the hierarchy are really rude to you"

Meg[1]*; Interview 1*

The issues of how the concepts of hierarchy and status might be apparent as existing between professions or within professions, or how hierarchy might be based on gender, race, age, seniority, knowledge or experience were discussed by the participants.

4.4.1 Between professions

Participants reported experiencing a hierarchy between professions whilst on placement:

"I've realised that when, most wards that I've worked at is...You've got students and then you've got OTs and physios... And then the nurses, and then the junior doctors and then the consultants at the top."

Amy[2]*; Interview 1*

"And I find there can be some hierarchy, especially with the obstetricians…."

Beth[2]*; Interview 1*

The issue of doctors being at the top of the hierarchy, and in particular consultants seemed to be common theme:

"a lot of people see the consultant at the top, the doctors, the nurses and then the therapy staff, um, that is the way, it is often seen. And I saw that more than once on placement."

Jo[1]*; Interview 1*

And Meg[1] explained how from her experience, this has negative effects with elements of superiority emerging which she felt quite strongly about:

"Consultants they don't give a shit about you ..they don't..they look at you in the office and don't, don't speak to you….

Meg[1]*; Interview 1*

However, Beth[2] was of the view that from her experience this was apparent, but may not be commonplace:

"Some of the doctors... Yes... Do have an air of superiority, I guess, But that's that's very rare."

Beth[2]*; Interview 1*

Amy[2] proposed that feelings of superiority were not confined to one profession. She observed that other individuals may deem themselves to be superior to others as a result of their position in the organisation:

"oh, I'm such and such, And this is my, you know, title. I won't do this or I won't go to such and such for this. You have to come to me, or I will not interact with this individual … like the ward manager, you'd never see the ward manager interacting with let's say the OT or physio, She always lets the other nurses do it.... and I don't know why it is like that. I don't know if it's like, just the lack of... I don't want to say, knowledge, or is it because of, she feels entitled. She's in this position, and then she doesn't feel like she's, you know , can go and speak to that person, that that person's beneath her"

Amy[2]*; Interview 1*

Some of the participants described experiences where a hierarchy had been apparent, or that the hierarchy had been exploited by individuals and this had resulted in a negative experience for the

participant. Meg[1] recounted observing an interaction between a consultant and a midwife over the care of a woman having a breach birth. She reported that although the midwife was acting quite appropriately and dealing with the situation in a correct manner, the consultant took over the situation and undermined the midwife:

"And the consultant was really disrespectful towards that midwife because she was facilitating what that woman had requested. And, you know, and that definitely was a hierarchical thing …. and although I can kind of appreciate what her concern is, actually that was really inappropriate because that was playing the hierarchy – I'm more important than you"

Meg[1]*; Interview 1*

Beth[2] recounted an unpleasant experience with a doctor:

"the first time I'd ever done a handover to a doctor... And he was very intimidating and kind of shot me down and picked holes in everything, and had a kind of smugness. My mentor commented on it. And that made me very apprehensive about doing it again"

Beth[2]*; Interview 1*

However, there was a recognition that this was not necessarily behaviour which should be expected from all doctors, rather the behaviour of one individual:

"but everybody said he was actually... He was grumpy.... This is how he always is, we had issues with him before. So maybe that was just him as a person, rather than a professional thing"

Beth[2]*; Interview 1*

Likewise, Meg[1] recounted a similar experience, this time with an anaesthetist:

I had one anaesthetist I worked with last year and he really shouted at me and I was really taken aback by it, and I think the only thing.. I really just wanted to burst into tears and run out of the room and I thought I can't do that.

Meg[1]*; Interview 1*

However, again she commented that this should not be seen as the accepted behaviour of all in the same position:

"all it did was it just made me feel a particular way about a particular person. I don't think I have a sweeping opinion about, you know, all anaesthetists are like that."

Meg[1]*; Interview 1*

Jo[1] experienced a situation where a doctor presumed that he could interrupt an assessment that she was doing in order to speak to the patient – where she felt a hierarchy was being demonstrated:

"I actually had the ward doctor come over, I was assessing somebody, the doctor wanted to speak to them… But, you know, that's just proof. Yeah. Yes. There is hierarchy"

Jo[1]*; Interview 1*

Interestingly Amy[2] referred to a hierarchy within the education setting, commenting on the privileged position held by lecturers:

"…in university you have the lecturers and stuff. So they are like in a blessed privilege, they're at the top and we're the students and we're at the bottom…"

Amy[2]*; Interview 1*

Jo[1] also referred to how she felt that in the classroom setting some groups of students placed themselves in a superior position to other groups of students and treated them with a lack of respect:

"there was a lack of respect as well, between some pathways….. I felt that the paramedics really looked down on us and to the point where at some point they were laughing at what we did quite rudely. And I was quite shocked at that."

Jo[1]*; Interview 1*

4.4.2 Within Professions

Alongside the recognition that hierarchies existed between professions, the participants also noted that there were hierarchies apparent within professions:

"..it's not just doctors..it's, you know, some of the midwives as well - there's a definite hierarchy there as well. I'm more important than you, or I'm a higher banding than you"

Meg[1]*; Interview 1*

"I think there's the hierarchy where there is obviously the consultants, the doctors, and whatever, they have their own hierarchy amongst themselves. So the junior doctors look up to the top doctor, and then with the nurses, you have your own hierarchy in that as well."

Amy[2]*; Interview 1*

However, Beth[2] was of the opinion that a system of status within a profession based on banding and seniority was different to a hierarchy which was apparent between professions:

"Sometimes I think it's not really a hierarchy, though, is it? That's not... That's a different kind of thing."

Beth[2]*; Interview 1*

Amy[2] recounted an experience of hierarchy both within and between professions. Talking about a patient who had returned from the operating theatre to the ward. Amy[2] said she was concerned

and raised her concerns with the nurse who said everything was fine, Amy[2] said she remained concerned and took her concerns to another nurse who likewise said everything was fine. Still feeling concerned she took her concerns to the ward manager who dismissed her:

"she dismissed me, she was like, Oh it's probably a bit of oedema, but there's nothing to worry about. If the nurses are not worried then you shouldn't be worried anyway. You should worry about other patients, not just that patient."

Amy[2]*; Interview 1*

Amy[2] said she had remained concerned and so spoke to the consultant who examined the patient and concluded there was an issue that needed to be dealt with, and that the patient could have died if this had gone ignored. Amy[2] said that the consultant took her to speak to the ward manager and expressed his concern that Amy[2] had been ignored. Amy[2] said that the ward nurse apologised to Amy[2]:

"she apologized to me, but it was like, a non-apology, I called it. And after we had a little huddle, a team huddle, all the nurses and everyone that was working on the ward…. I felt like it was like a pack of lions and I was like the little cub in the middle. And some of the nurses were really good, …at least some people, apologised and said "Oh actually, you know, we could have done some things a lot different. Whereas some of the nurses … the nurses that had actually looked after the patient weren't really nice and they were saying things, like, "Oh so you think we're not going to treat you any better now because you've done this ... There is a code on the ward, and you've just gone against that code"

Amy[2]*; Interview 1*

Amy[2] expressed mixed feelings about the role of hierarchy in this situation:

"I thought, you know, the positive that I got from that was, from the hierarchy in that situation was...Yeah. You know, the consultant listened to me, He didn't doubt me... he listened to what I said, he asked me questions.. he explained things to me... Whereas in that same hierarchy, the nurse on that ward, she dismissed me, and because she dismissed me, she agreed with all the other those nurses, and then, those nurses, you know, it was like a little team thing… And I just thought, like in that instance... in terms of that hierarchy, some people were really, really good. And I felt, like, maybe the hierarchy then works in that instance ..."

Amy[2]*; Interview 1*

4.4.3 Other factors

The participants seemed to feel that there were other factors involved in any perceived hierarchy other than professional groupings. At times it was suggested that there was a hierarchy based simply on how long individuals had been employed in a particular post:

"Just older people, I think, feeling like... cos they're older, they've got more... I don't know if authority is the right word.. But, because they're older, they're more important.."

Meg[1]*; Interview 1*

However Meg[1] also highlighted an experience where a midwife with a number of years experience behind her was willing to listen to her, even though she was a student:

"she said, look I might have be doing this for 25 years, but you're in education at the moment, you're the one that's going to know the most up to date stuff, you're going to know the most current research. And she said if there is something that I say that is not right, tell me."

Meg[1]*; Interview 1*

Amy[2] proposed that the issue of age may also be linked to an unwillingness to change the way in which things are done.

"…the younger ones. They are more open to change whereas I feel, like, with the older generation and elderly health care professionals who have been working for like, Oh I've been doing this for 30 years.. you can't tell me to do anything different, I think they're a bit closed off and they're not open to change."

Amy[2]*; Interview 1*

For Meg[1], there was the issue of gender which impacted on hierarchy:

"it is the hierarchy of the sexes as well, because I know that female doctors will be much more likely to speak to me and interact with me and the male doctors won't even acknowledge that I exist"

And for Amy[2] the issue of race has a part to play:

"there is like a cultural hierarchy.. where, you know, the white nurses are at the top. Then you have another race in the middle and then you have another race at the bottom, and you think, oh, my God, you're all nurses."

4.4.4 Challenging Hierarchy

The analogy of the pack of lions and the little cub alluded to by Amy[2] earlier was reflected in comments expressed by the participants in relation to a reluctance or discomfort to be seen to be challenging hierarchy, or to challenging individuals within the hierarchy. Amy[2] talked about being 'terrified' by the fact that she had been seen to have challenged the opinions of the senior nurses by going to speak to the consultant. It seemed that this was a difficult thing for others to do:

"I still think because the way hierarchy is a lot of people don't say anything because of that fear. You know, I can't tell them how to do their job can I.."

Meg[1]*; Interview 1*

Jo[1] recounted how the hierarchy was challenged by a service user, when a doctor presumed that he could interrupt an assessment that Jo[1] was carrying out, and how uncomfortable she felt:

"I was only in my place as a student and I was more than happy to get up and say, yeah, do what you got to do I'll come back. She was horrified, and she just said, "don't you dare move...And she said, excuse me, we're in the middle of something. You know, how dare you come over and be so rude to the.... I mean, as a student, you can imagine I was going red from here upwards and I quietly made my apologies and escaped.."

Jo[1]*; Interview 1*

In a similar vein, Meg[1] recounted how a fellow student had challenged a consultant, and when she and her friends had heard about this they had expressed shock that she had 'dared' to do such a thing:

"one of my friends ... she challenged, she challenged a consultant over something.. their decision ... she said, why can't we do this...And we were all like, "OOOH, you challenged what they said!!" … we were like, "Oh she challenged, you know, challenged someone in authority"

Meg[1]*; Interview 1*

So there is a concept that even if it may seem appropriate to challenge a decision made by someone 'higher up' in the hierarchy, individuals may be unwilling to do so as it is seen as uncomfortable to do so and perhaps carries an element of risk.

However likewise there was a view expressed that where a hierarchy or authority was based on knowledge of a specific area, it may be inappropriate to challenge:

"I know what that job entails. I know... I know what my role is within that team. I wouldn't presume to go into theatre and know where all of the equipment is…."

Beth[2]*; Interview 1*

Jo[1] offered the opinion that traditionally her profession, Occupational Therapy, had not been perceived with much respect by other professions but that traditional hierarchy might be challenged as the profession developed:

"I think if there is a hierarchy, it makes the ones that feel that they're the dogsbody, so to speak, speak out more, stand their ground more. Um, yeah. I mean, I can only talk from an OT perspective, and I've seen that grow in the three years that I've been just as a student, um, that the profession is growing in confidence and is willing to stand up for what it believes."

Jo[1]*; Interview 1*

"So there's definitely a hierarchy that exists. And until... that's just something that will change over time, and is as, OTs are moving into management positions and stuff, that will change over time"

Jo[1]*; Interview 1*

Likewise Beth[2] was of the view that hierarchies are more likely to be challenged now than in the past:

"health care was allowed to be a hierarchy… I think it takes a while to break down those hierarchies that were there perhaps, when other generations were in active practice."

Beth[2]*; Interview 1*

Amy[2] recognised that her perception of hierarchy had already changed:

"…it's little things like hierarchy, it's changed because whereas I always thought, you know, if you're at the top, you're always right. Now, I know that... you know.. You don't. People don't always know everything."

Amy[2]*; Interview 1*

4.5 Facilitation

Perhaps one of the most significant influences on their experiences of IPE cited by the participants was facilitation. This included the organisation of the sessions and the attitudes and conduct of the facilitators themselves.

4.5.1 Organisation

How the IPE sessions attended by the participants were organised was important in a number of ways. The participants expressed the importance of seating arrangements to encourage interaction between the professions:

"the first day we were in one of the seminar rooms in like where you know the chairs are all in lines and you you sit back and everybody sat with each other and there was no seating plans … so the midwives sat on that row and the ODPs sat on that row, and then mental health sat back and everybody was very separate… The second year we went in and they were, there was tables with already mixed groups, and it was smaller groups, with say two midwives, two nurses, two adult nurses and ODPs or whoever else, mental health, whatever was there... So we were already forced to mix, I guess, is the word. But actually that was quite effective because we sat down and we were like 'Oh, Hi, where are you from'? And discussed... there was already introduction, and you were forced to mix with other people"

Beth[2]*; Interview 1*

"I think that's why I got more out of the second year than I did out the first year. There wasn't really any mingling in the first year."

Beth[2]*; Interview 1*

"the reality was that actually people still sat on the same tables of their pathways. We weren't encouraged to mix…. So. Yeah, it was just I think the worst thing was that people stuck to their own, they didn't mix."

Jo[1]*; Interview 1*

"We were put in different groups... And in those groups it was... I worked with people that I didn't work with everyday."

Amy[2]*; Interview 1*

There was also the perception that where experiences were organised as voluntary activities as opposed to mandatory events, this affected the experience in a positive way:

"because if it's voluntary you want to be there, don't you? Whereas your lectures .. you are kind of 'bound' to be there by signing up to come to university"

Meg[1]*; Interview 1*

4.5.2 Role of Facilitator

The participants additionally expressed how crucial the role of the facilitator played in their experience of IPE. Jo[1] reported that the facilitator advised against mixing with other professions on the basis that completing the assignment would be logistically easier if they remained within their professional groups:

"one of the lecturer's words were, if you stick with 'your own', you find it easier to meet up to do the work. And that's not the aims of the, of the Module"

Jo[1]*; Interview 1*

Similarly, the attitudes and the actions of the facilitator were crucial in Meg[1]'s experience and she felt were the fundamental reason why she had a negative experience. When comparing her first and second years experiences she pointed out the differences in attitude of the facilitators:

"Our teacher in our first year, I have to say she was really really good. She was really good. And I think her.. She was really enthusiastic…. but because she was really enthusiastic about it, I think that really helped us to help us to be enthusiastic and to help us engage. And I think. Yeah. You know, that was really good. I don't think perhaps in the second year there was.. we had someone different and I don't think they were as enthusiastic."

Meg[1]*; Interview 1*

"I think that's where the difference is, perhaps sometimes with the teaching in terms of teaching, you know, for that first year of the lecturer being engaging and really enthusiastic, you could see she wants to be there, she wants to be teaching. And she knew it was really important….she had quite a lot of stories that she told us from her own experience, that really highlighted where, you know, there's been good collaborative practice and where actually it had fallen flat on its face and you related it to practice and how that impacted on her patients or her clients or whoever she was looking after.. And with the second year lecturer, she had a lot of stories to tell as well, but she wasn't sort of enthusiastic, I don't think, and I think it felt a little bit more...second year was a bit.. ticking things off a list – we've got to do this, we've got to do this ….But it's that, that seed isn't it that plants in your mind, that's what goes in there – do they really care?"

Meg[1]*; Interview 1*

Meg[1] identified the attitude and enthusiasm of the teacher to be key to any learning activity:

"I think any person can relate to the fact that if you walk into a taught session and you come in and your teacher is enthusiastic and 'Right this is what we're going to do today? You know, and they've got that sort of buzz of energy that you immediately sit up. Oh, OK. What we doing then, you know, this could be interesting. Whereas if you have somebody who comes in and they're a few minutes late and they're a bit flustered and they've got paperwork everywhere, and they're not very organised and they're like 'Oh we've GOT to do this today."

Meg[1]*; Interview 1*

She also expressed a disappointment in the way the IPE sessions she was about to embark on as part of her third year Collaborative Practice module had been introduced:

"I don't feel inspired to go. And we had our first session of our third year three weeks ago. And I have to say the introduction actually gave me no inspiration to go to any future lectures on it at all…"

Meg[1]*; Interview 1*

Meg[1] explained that in her view, there had been several incidences where there had been a poor choice of words by the facilitator in the introduction which had disengaged her before the module had started. Meg[1] is a former teacher and is aware that her view on teaching will have contributed to these reactions:

"And we were told, and this is what was said, the words were, "Don't expect to be taught when you come to collaborative practice, the lecturers are here to facilitate you, not to teach you." And as a teacher, I think "Well there's no point in me coming is there because I'm here to learn, I'm here to be taught … I think saying those words of "don't expect to be taught" is a bit like, "well, if we're not going to be taught, we're not going to learn so what's the point of coming"….I think the language is quite, that's quite a negative thing to say"

Meg[1]*; Interview 1*

"I think it was that choice of words that was poor. ... But I do know it's just something I would never have said as a teacher, to anybody, don't come to.. you know.. don't expect to be taught... Poor choice of words I think... She should have said, you know, these sessions will be facilitated, more emphasis will be put on you as individuals to, to take the learning forward. I was shocked, I think, by the choice of words. Just surprising."

Meg[1]*; Interview 1*

"..after what was said – it's kind of pissed me off to be honest with you. But that's how I feel – I feel a bit cross by it and I feel a bit like, I don't know, I just go back to the fact that those were the choice of words and it upset me and upset it me because. I didn't like what was said.."

Meg[1]*; Interview 1*

"..and they're like 'Oh we've GOT to do this today.' Again, it comes back to that choice of language. 'Oh we've GOT to do this', which makes you kind of think, OK, yeah, We've got to do it, like it's a hardship, it's going to be boring, it's going to be hardwork – it's a language thing, isn't it?"

Meg[1]*; Interview 1*

Likewise, Meg[1] identified the methods of delivery of the session as being crucial to her experience:

"You look at some things and you think 'that could have been a bit better, that session was a bit dry"

Meg[1]*; Interview 1*

"I think that some of the way some of the sessions are, with them being very dry and very, you know, we sort of go in and sit ourselves down and we make ourselves comfortable with our drinks and our sweets because we know it's going to be a long road."

Meg[1]*; Interview 1*

Meg[1] suggested that although she understood the value of IPE, the delivery of the taught IPE sessions had been poor, and that this had also affected the attendance at the sessions by the student group:

I totally see why we need to do it, I think it's a really valuable thing to do, I think we have a lot to gain from it? But I think a lot of the way it's put across is very.. it's just not very good. And I think that's why people don't attend.

Meg[1]*; Interview 1*

Jo[1] echoed these comments about non-attendance to the IPE sessions….

"we had such poor attendance…"

Jo[1]*; Interview 1*

.. and suggested that this lack of attendance by others impacted on her own experience:

"It was just, it was just something stopping it working. It should have worked on paper. It should have worked. Um. Obviously, lack of attendance, you know, that's down to the individual that doesn't help…"

Jo[1]*; Interview 1*

Meg[1] referred to a positive experience that she had where she attended a multi-professional study day:

"…and it was all different professions, so there were doctors... it was chaired by local GP.. the police were there, social workers there and, uh, nurses.... and then we were in a massive lecture theatre.. and we were split off again into groups of all different professions, and we went and had like a big meeting round a big table. It was chaired by one of GP's. And we had like a case that we looked at and we all sat and talked about it and discussed it, and actually that was a really good experience. And it's good to see how, you know, different professionals looked at different things as well... Their

perspectives, I guess, isn't it... and that that was really valuable. I think something similar to that is really, really good"

Meg[1]*; Interview 1*

She explained that she believed her experience of this event was more positive due to the facilitation and delivery methods adopted:

"But it was a really good experience, you know, in all. But that's what it could be like. That's what I think. That's what I think it should be like more.... less sitting at the desk and listening to lecture, and more practical activities and stuff, you know."

Meg[1]*; Interview 1*

There was also the suggestion that IPE is a more positive experience when the activities that are engaged in are more practical and less theoretical:

"sitting in a classroom… just doesn't have as much value as perhaps working with, you know, actually doing stuff physically, practically with people who you are going to be working with"

Meg[1]*; Interview 1*

Jo[1] expressed the importance of continuity, of having the same facilitator from one session to the next and understanding what the lecturer was looking for when it came to submission of the assignment:

"one year we had a different lecturer every session. So when it came to handing in the essay, I had no clue what they were looking for, couldn't gauge what they were looking at and that showed in my results."

Jo[1]*; Interview 1*

4.5.3 Engagement

It was clear that the participants were of the opinion that IPE required engagement from the student in order for them to benefit:

"I think if you're into it or if you're into... If you want to know about something and you do your bit and you take part, you will see that it is .... It does work"

Amy[2]*; Interview 1*

Beth[2] seemed to express frustration with those students who chose not to engage in IPE, to mix with students from other professions and were reluctant to leave the comfort of their own professional group:

"I'm kind of of the opinion that actually we're all in it together and they probably weren't happy about not sitting with their friends either. I don't think. But we're grown ups and we're gonna be working together. So let's work together and get the best out of it. You don't get the opportunity again. That's the one DAY in our academic YEAR where we get to sit down with the paramedics, or the mental health nurses, or the nurses, or the ODPs. And, and let's make the most of it."

Beth[2]*; Interview 1*

Meg[1] recognised that her own depth of engagement relied on the facilitation of the IPE sessions. She seemed to recognise this perhaps as a negative personal attribute which could prevent her from getting the benefit from learning opportunities. She likened herself to a 'teenager' in this respect:

"I've always been quite a teenager. I think, in terms of my own learning, you know, If I'm not happy with something, I throw my toys out of the pram and have a sulk... But I think that's definitely how I feel about collaborative practice at the the minute after going to that session, and after what was said – it's kind of pissed me off to be honest with you….. I know I'm going to go into the next session, and I'm going to do the teenage thing and I'm going to sit there with my arms folded and face like thunder, expecting, you know, something awful and terrible. I really hope I'm going to go in there and be wrong and actually is going to be brilliant and I'm going to go away thinking OK, you know what I'm doing now, but I just feel, yeah, that's kind of how I respond. I can't pretend otherwise cos I know that's who I am and that's what I do...."

Meg[1]*; Interview 1*

Interestingly, through the process of the interview, Meg[1] had reflected on this issue and at the end demonstrated an intention to address this moving forward:

"but I'm think I'm going to go away. And I'm going to go to my next CP session and I'm going to go in open minded and see what happens – I'm going to try and go and not be a teenager And I'm going to be open and see what happens, and see how it goes from there."

Meg[1]*; Interview 1*

Amy[2] described how she had benefitted from IPE in terms of understanding the value of engagement and she was transferring this into her engagement with her programme more generally, probably linked to the increased self awareness she had gained from IPE previously described:

".. And then I hadn't done it because I didn't engage, because of whatever reason. But ... now I do engage. I forced myself to engage... I literally go when I have my initial interview. I then say this is what I want to achieve. Can you help me achieve this? …. And then because I've said that to them, their response is different. And then the way that they try and accommodate me and let my skills ... the communication was different because I've done ... whereas before I would have just ... listened to what they say "Oh you're going to do this, you're going to do that...We might be able to do this. And I'd just leave it ... But now I literally just go in there and say this is such and such and such is what I want to do .. and not being, you know, being abrupt, or being harsh or, you know, being too forward

per se, but just stating that, you know, I'm a student and I know what I need to learn and what I need to achieve."

Amy[2]*; Interview 1*

4.6 Perceptions of IPE

Overall perceptions of IPE emerged from the interviews but varied between the participants.

Amy[2] in particular was very positive in her views of IPE:

"I don't think there is anything negative about it."

Amy[2]*; Inteview 1*

Amy[2] is in the S17 cohort and followed the 2018 programme where individual programmes embed IPE into the curriculum delivery, and participate in 'core' IPE days. It clearly emerged that she wanted more formal taught IPE sessions in her curriculum:

"I would love it to be, like, a module because I feel like, it is an experience. That's what I called it, actually. I feel like IPE is an experience. And for you to actually get the full experience to consciously have that, you know, in a couple of hours, I feel like it has to be like a journey because I thought I had my journey in a space of a couple of hours."

Amy[2]*; Interview 1*

Amy[2] referred to her experience in IPE, and the increase in self awareness which she felt she obtained as being quite profound – referring to it as a release:

I don't know if it's because I became aware of something that I did on that day that's why I feel, like, maybe there is more to it ... or.. that's what IPE is.. and because I was just, you know, in this bubble and it just burst and I had all these like feelings and thoughts that I do have, that's why I think there's more to it...

Amy[2]*; Interview 1*

Likewise, Beth[2] had positive views of IPE:

I don't see what could be negative about it, really. I don't see what could be wrong with it. I can't see any negatives.

Beth[2]*; Interview 1*

Beth[2] is also in the S17 cohort and followed the 2018 programme. She equally expressed a desire for more:

So I think we might benefit from having....more....please

Beth[2]*; Interview 1*

I think it might be nice to do something together just once in a while, rather than like just the …. BIG days... maybe just have a few odd lectures, that would be quite nice

Beth[2]*; Interview 1*

Conversely, Meg[1] confessed to having a rather negative perception of IPE.

I've got a really bad attitude towards it – I've got quite ill feelings towards that, which doesn't make me happy.

Meg[1]*; Interview 1*

Meg[1] is in the A17 cohort and followed the 2012 programme in which students study one collaborative Practice module (CP) per year. This negative view of IPE has largely been formed by her experiences as previously described, in terms of facilitation and relevance to her of the Collaborative Practive modules. This may be supported by the fact that she did identify some positive experiences from the supplementary, voluntary IPE activity she attended. She was also keen to point out that whilst here experiences may have been largely negative, she does have a positive view of IPE and what it is aiming to achieve:

my views on it aren't all negative. Yeah, my views are quite positive, but just my experiences haven't been good.

Meg[1]*; Interview 1*

Likewise, Jo[1], who is also from the the A17 cohort and followed the 2012 programme described a broadly negative experience of IPE. She explained that she felt let down by the delivery of a subject which she had thought she would find interesting and stimulating:

"In the collaborative practice, I mean, it was there, it had the makings of what I just thought was a really good module. But there was barriers, it was just like there was barriers and I don't know if that was by the people, or course, I can't say really… It was just, it was just something stopping it working. It should have worked on paper. It should have worked."

Jo[1]*; Interview 1*

She explained that the timetabling of the sessions, with them being spread over the year may have had an impact:

"And there's such a big gap between when you have one collaborative practice session to the next. That probably doesn't help either. So maybe, um, maybe if those sessions were told over a term rather than a whole year. That would, I think, that would make a big difference. Um, with them being so far apart, even though you'd get a whole week, you're only in two those days in that week. Um, so you don't get to know the lecturers you don't, you know, it just doesn't flow. So maybe that was the biggest barrier was the gap between one session and the next."

Jo[1]*; Interview 1*

"It just.. It means it needs to be bigger. It needs to be made more of a thing of.. I think where it's spread out, that automatically it loses credential, if that's the right word.. because it's, well, we're only doing it three times a year, it can't be that important? I'm not saying necessarily it should be done more... But it should be made more of ..Um.. How you go about doing that, I don't know, but, yeah, I think it needs to be made a bigger thing. It needs to count more. It needs to stand up and say, yeah, this is actually part.. A big part of your learning. And I don't think it does that."

Jo[1]*; Interview 1*

But like Meg[1], despite her negative experiences, Jo[1] stated that her overall perception of IPE and what it is aiming to achieve was positive:

I think, um, I think it's positive. I think. A lot can be gained from it. Providing it's delivered in the correct way, so, the whole idea of interpersonal learning, I think is brilliant. Actually putting it into practice, I think sometimes it's needed to be re-looked at...

Jo[1]*; Interview 1*

4.7 Summary

This chapter presents the results from Interview 1 with participants in this study. The results were presented by the themes which emerged from the interviews. An overall analysis of the outcomes of the interviews and a discussion of the findings in a broader context relating to the published literature will follow in chapter 6.

5.0 Chapter 5. Results; Interview 2

5.1 Introduction

This chapter presents the results from the second interviews with the participants. Again, the results reflect the thoughts and comments of the participants and the interpretation of those by the researcher. Direct quotes from the participant interviews make up a great deal of this chapter together with analytical comments in line with the concept that the interpretation is grounded in the data (Smith et al 2012). Once again the use of dots (….) in the quotations indicates where extraction of less relevant words has occurred during editing. Likewise, for the clarity of the reader, the two students who followed the 2012 curriculum (Meg and Jo) have been annotated as Meg[1] and Jo[1] and the two students who followed the 2017 curriculum (Amy and Beth) have been annotated as Amy[2] and Beth[2]. The results are presented without reference to existing literature and separate to the analysis and discussion.

5.2 Contextualising IPE

Once again when asked to discuss their experiences of Interprofessional Education, some of the participants immediately referred to the formal classroom based, organised sessions as part of their taught curriculum:

So we've had another session of IPE since last time..

Beth[2]*; Interview 2*

"the last six months has involved..us.. having collaborative practice lectures"

Jo[1]*; Interview 2*

"I'm going to think back to the start of our year three year when we were called into the lecture theatre…"

Meg[1]*; Interview 2*

However, others' first response was to refer to non-classroom experiences. Amy[2] referred to a more varied experience, reflecting on an elective placement in India in addition to her experiences in the UK:

"..since the last time, I think I have, um, had quite a bit of experience, well quite a bit but a bit varied, because I've had experience here and then I've had experience on my elective experience in India."

Amy[2]*; Interview 2*

This seemed to be a powerful and memorable experience for Amy[2], enabling her to draw comparisons between her experiences in the UK and in India. This element of her experience will be reviewed in more detail subsequently.

As in the first interviews, all the participants often referred to IPE happening beyond the classroom and again did not seem to consider IPE as something that happened in one particular setting. Again the participants consistently described working with members of their own and other professional groups, particularly qualified staff, as being synonymous with IPE.

Once again the analysis of the second interviews produced the same super-ordinate themes as the first interviews of Learning about or from others, Hierarchy and Status and Facilitation together with some lower level themes. However, as with the first interviews, there were some additional issues that were not common and could not be considered to be themes as only one or two participants identified them, however they were sufficiently strong elements in the individual transcripts to warrant inclusion.

5.3 Learning from or about others

As with the first interviews, learning from or about others came through as a strong theme in their experience of IPE for almost all the participants. Learning about the roles of others emerged as an important aspect of their experiences of IPE. Again the participants expressed the benefit in having a knowledge and understanding of the roles of others, but also the perception that it was beneficial not only to others, but also themselves if others had an awareness and an insight into the roles that they were performing.

5.3.1 Roles

The concept of IPE enabling an understanding of the roles of others was again clearly important to the participants. Jo[1] talked about the value of this;

> *"it's good to see other people's roles. It's good to hear other people's opinions.*
>
> Jo[1]*; Interview 2*

And she explained that this was one of the most positive aspects of IPE for her:

> *"…the realisation of other professions"*
>
> Jo[1]*; Interview 2*

In fact she offered the view that without the interprofessional element of the programme, she would have had little opportunity to learn about the roles of others since the curriculum of her professional programme did not facilitate this:

> *"Not within, actually within, not our OT degree, There is no.... I would say.. We very rarely talk about other professions, very rarely. Um. Occasionally, we might mention the physiotherapist…. but.... I don't remember particularly any profession being mentioned throughout out the degree.."*
>
> Jo[1]*; Interview 2*

Unlike Jo[1], Amy[2] commented on examples where learning about others had been included in her programme:

"Time for dementia, that's interprofessional cos we had to work with the Alzheimer's Society this year, go into people's homes, like you were buddied up with a family... the social justice module, I would say that's part of it cos that made us be able to challenge things that we would not, never, challenge like the curriculum, educational side of things, like there was some things that we could say in that social justice module. We would never dream of saying them, you know, outside or even within the university.... we did it as student nurses, but then we ended up doing it with other students, like mental health, just to see the experiences and then compare...."

Amy[2]*; Interview 2*

Beth[2] agreed that it was important to understand and know about the roles of others;

"I think awareness of what everybody else is doing is very, very important.. Um.. We do, we act in silo of each other don't we, and it's not like that necessarily. So it's quite nice to have the opportunity to learn what everybody else is doing and what their role is"

Beth[2]*; Interview 2*

The concept of 'silo' working was clearly an issue for Beth[2]. She was concerned about a tendency for professions to be inward looking and offered the view that IPE gives an opportunity to be more outward looking:

"We get very used to being within our own cohort and our own profession, particularly within a university setting, and then to a certain degree, within placement. But it's not just us and we're not on our own. It's like that one man on an island. It's not just us. There's so many other people involved and there's so many other professions involved and so many ways that these, these things interact with each other. Um, it's nice to get a view of outside of that."

Beth[2]*; Interview 2*

Amy[2] offered the opinion that whilst the curriculum did provide the opportunity to learn about the roles of others, it did not allow her to develop the skills to enable her to actually work with other professions:

"So the curriculum will tell, you know, this is who needs to be there and this is who you'll work with. But then how you do that..."

Amy[2]*; Interview 2*

She went on to suggest that students could not rely on the curriculum to provide them with a full grounding in IPE, and that they would need to be more pro-active and seek out opportunities for themselves.

"I feel like it's not there yet. I feel like we have to proactively do something ourselves as students."

Amy[2]*; Interview 2*

Amy[2] appeared to be concerned that if students were not pro-active and sought out opportunities to learn with and about others, there would be a perpetuation of a lack of understanding about others roles:

"Whereas there's things that I can do personally proactively. But that doesn't mean someone else is going to do that. And then it may be that I'm one of five out of two hundred and seventy five people. And then it just goes back into practice and maybe people qualify and then they just stick to what they know."

Amy[2]*; Interview 2*

Jo[1] talked about how she had learnt about others' roles, from placement rather than classroom based experiences:

"Definitely on work placement, yeah, um. Not through, not through the theoretical side, but, yeah, certainly work placement"

Jo[1]*; Interview 2*

Meg[1] also explained how she had learnt about the role of others through experiences on placements:

"I didn't know what ODP was until I went to theatres"

Meg[1]*; Interview 2*

"I did a placement in A&E in Minor Injuries… I worked with them and doing that helped me understand a little bit about maybe more about what they do."

Meg[1]*; Interview 2*

However Meg[1] also showed concern that she felt there remained a lack of understanding of others roles between professions:

"I feel from being in practice there's maybe a little bit of... lack of understanding of each other's roles in some ways and maybe a little bit of a... Lack of understanding of.... What our focusses are.."

Meg[1]*; Interview 2*

"And that's where things make me think, that there's a lack of understanding of what our roles are and things. and I definitely think there's, there's a bit of a lack of communication."

Meg[1]*; Interview 2*

Meg[1] went further and said that she felt that there was some fundamental flaws in the way in which professions worked together from her experiences on placement:

"Somethings are really really rubbish at the moment in terms of interpersonal working at my placement site."

Meg[1]*; Interview 2*

Meg[1] also suggested that other professions – she referred directly to the doctors – had a lack of awareness of the roles of others:

"from my experiences working in the hospital, I don't feel like the doctors always appreciate maybe what I'm trying to do, where I'm coming from…"

Meg[1]*; Interview 2*

This was a concern and a frustration echoed by Jo[1] who commented on a perception that students from other professions – she referred directly to paramedic students – seemed to be of the view that interprofessional education is irrelevant to them because they do not work directly with other professions:

"According to them, they don't collaborate with anybody. And there was a lot of "this is irrelevant to us."

Jo[1]*; Interview 2*

Amy[2] reflected on how she had learnt about the roles of others during her time in India. It emerged from the interview that this came about because when she was visiting a hospital in India, she was placed in an area which was unfamiliar to her – working with children with Learning Disabilities. She said initially thought this would be a positive experience for her:

"I would never get to do this home, I'm just an adult nurse, I don't even get to work with children. So I thought this is a good experience. And it was good because then I'm working, you know, with the learning disability team…"

Amy[2]*; Interview 2*

However, she reported that the she soon found she was uncomfortable with the working practices that she observed:

"….they would like um, like have tied a brick to like, a kids leg to weigh them down so they don't run off….And they were like 'Oh because she runs off and, you know, we haven't got enough staff to be chasing after one child'..."

Amy[2]*; Interview 2*

Amy[2] said how she contacted a friend at home who worked in the area of Learning Disabilities who taught her about activities and interventions that Learning Disability nurses engage in, and Amy[2] took these ideas with her into the placement:

"I have a friend that works with children with learning disabilities at home and I would go on facetime. And I'd speak to her and ask… what other things can I do with the kids to keep them

entertained? Or there's a child with like cerebral palsy, what can I do with that child to keep them engaged when I'm there… or are there exercises I can do with the children…. they would tell me things about like sensory stimulation or just like arts and crafts or games and sometimes just a bit of attention….So then I would do that, you know, go back to the school and then do like a bit of different activities and games or like, make, um, arts and crafts like make a little sensory things like with buttons and scrunchies like crisp packets and I'd like take them to glue them to bits of paper so they can play with them and that actually engaged the kids because it was something different…"

Amy[2]*; Interview 2*

This led Amy[2] to not only learn about practices beyond her own profession, but also to appreciate another profession:

"And I appreciated my friend for that, I would have never gone to.. If I was at home, I wouldn't have had that experience of me saying to her, because we just have normal conversation "how was placement did you have a good day. Yeah. That was it. But then here, actually I went to her for help and input professionally"

Amy[2]*; Interview 2*

Amy[2] also explained how she had learnt about the role of the Physician's Assistant from a student from America who was also on the India trip:

"I thought that was interesting because we got to sit down and talk about her role as a physician's assistant and my role as a student nurse and the knowledge that she had."

Amy[2]*; Interview 2*

She also explained how she had been supported by other students during the trip:

"And she helped me… we'd have like an hour of reflection after our day at work"

Amy[2]*; Interview 2*

"So she's like, you know, giving me a lot of different tips on how to communicate with the doctors to see like, maybe did you try this …. she said, OK, do like a little role play. I'm the doctor, and you're you, now you ... like say how you introduced yourself or how the communication was today and we would role play that out."

Amy[2]*; Interview 2*

Conversely Meg[1] felt that from her experience, members of other professions did not take the opportunity to inform her about their roles, their perspectives and why they worked in the way that they did:

"I think that again is a really missed opportunity particularly for the doctors, because actually if they took a second to maybe talk to us and go actually do you know what, this is what we doing, but this is why I'm going to do it... That's a really massive learning opportunity for us. And that's a really important opportunity for us to build a rapport with that doctor, to learn from that doctors, have an

understanding of what they're looking at, and the decisions that they're making, why they're making them, cos quite often you walk away going I don't know why they chose to do that."

Meg[1]*; Interview 2*

Meg[1] also reiterated some of the concerns she had expressed in the first interview about the 'relevance' of her experience of IPE in the formal classroom setting, discussing once again how she felt that these had been with students from other professional groups with whom she had, or was likely to have little professional interaction, and so there was less relevance to her in learning about their roles;

"…it's nurses and midwives. And actually in the grand scheme of things, our paths very rarely cross. We come into contact with neonatal nurses sometimes, but apart from that, we don't come into contact with them at all. And I think that there's a missing element here, that we should be doing the collaborative practice with the doctors really, because those are the people who, as midwives, we work with on the obstetric led unit every single day."

Meg[1]*; Interview 2*

"I think that's the opportunity that's being missed at the minute with bringing, you know, cohorts of students together, it should definitely be the doctors and the midwives.. I think it's really limited having the midwives and nurses together.."

Meg[1]*; Interview 2*

Jo[1] was in agreement that the classroom sessions were more beneficial when she was in them with students from professions who she worked with, or was likely to work with on a regular basis:

"I think some of the people that that we are put with to work with, actually we don't come across. And so maybe that needs to be... more streamlined.."

Jo[1]*; Interview 2*

"it is good to see other people's roles, but some of them I wouldn't come across, or very rarely would come across..it was beneficial with some, not so much with others who I know I'm not going to really cross paths with."

Jo[1]*; Interview 2*

However Jo[1] did concede that although as an OT she would rarely come into direct contact with some other professions, the work that those professions did was important to her as an OT in an indirect way and so it was useful to have an opportunity to gain an understanding of what they did and their role;

"We wouldn't come across a radiographer. However, their work is important to my work. So I suppose in that sense, it's good to understand that role"

Jo[1]*; Interview 2*

As with the first interviews, it was apparent that it was important to the participants that IPE offered opportunities for others to learn about the participants' own roles. When considering the classroom sessions she had attended, Jo[1] felt that even when her profession was not identified in the case studies that were looked at, she was able to educate her fellow students about where OT may have featured:

"So there was nothing focused about OT, in most of the case studies OTs weren't even mentioned it was nurses, maybe paramedics were mentioned, but it was mainly, it was mainly nurses…. but that didn't matter because it was about... It was about the whole... even though it wasn't specific to our profession, we were still able to show how we would work alongside the others."

Jo[1]*; Interview 2*

Likewise, Amy[2] referred to an example of how she had been able to educate members of another profession by passing on the knowledge she had learnt from her Learning Disability nurse friend to the teachers in the nursery in India:

"and then it also engaged the teachers in the school because they were like, oh, this is a good idea. And I was like, Yeah. You know, you don't always, you don't have to have the best of equipment. You can make the most of what you have. And because, like, it was really littered in India and so much dirt everywhere. So I was like, you know what we can do.. like I'd make a recycling bin and I was like put all the plastic in it and then all the other rubbish in another bin. And then when I come back the next day, we can fish out all the papers and we can do a bit of arts and crafts with them to make sensory bits for the kids."

Amy[2]*; Interview 2*

"This actually works .. people communicate and the whole interprofessional thing, you know, like I'm a student nurse, but then I'm helping, you know, children in the Learning Disabilities School….They were a bit distant to start off with, but when I started doing all this and implementing little bits of activities and stuff with the children, they were receptive. And they were like have you got more ideas about that, oh, I could do this. So that was really good."

Amy[2]*; Interview 2*

5.3.2 Breaking down barriers

Amy[2] referred to the importance of IPE and Collaborative Practice promoting the concept of breaking down barriers between individuals and encouraging the building of teams, a team ethic and teamwork:

"the end goal is, you know, the patient gets the right treatment. And if you do something wrong, we're all liable because whatever you do wrong, it then comes to us because we're working as a team. So if you're part of a team and we welcome you, you know, you want to work in the system"

Amy[2]*; Interview 2*

And Jo[1] likewise referred to this concept of a common goal rather than individual, uni-professional agendas:

"you are all working together, you know, you've got one goal, which is for that patient to become well enough to leave hospital"

Jo[1]*; Interview 2*

Beth[2] also offered the opinion that having an understanding and an acknowledgement that different professions might do things in different ways, and appreciating these differences, could break down barriers between the professions rather than building them up:

"... we have to recognize that there are ...midwives do things a certain way, Nurses do things a certain way. They have that, you know, everybody has their own point that they are approaching it from, um. And the behaviours and the… Um, not teamwork structures … but the way they interact … might be different between different professions, but just being aware of that and not letting it, not letting it be a barrier but, like, but like something that's unique to them and something that's appreciated I think is important."

Beth[2]*; Interview 2*

5.3.3 Contact

As in the first interviews, the participants talked about having contact with students and professionals from different groups, and how that contact with individuals might affect perceptions of other professions as a whole. Beth[2] reflected on how an opportunity to have a discussion with a junior doctor allowed her to gain an insight into how the junior doctor had been feeling during the situation being discussed, which then led her to view other members of that profession from a different perspective:

"I had quite a valuable learning opportunity with one of the...more junior doctors on placement… The woman that we were caring for had kind of been.... not forgotten, but become less of a priority in that situation, which I then raised to my mentor and we spoke to the doctor about it and had a really lovely discussion with her. She sat down. She took time to sit down with me and say, actually, she felt very vulnerable in that situation, too, because her seniors had left her and, you know, there were several small things that contributed to the situation as it was. But it was lovely that she sat down and had a conversation with me. And we spoke about how we were both feeling. And actually… I have a lot of respect for her that she held her hands up and said it wasn't ideal for me either. I'm really sorry that you perceived it that way. And then there's kind of a stronger camaraderie now from that, that's emerged. I think it's very easy to forget that, um, other people could be put in difficult positions, too, um, particularly when they're more senior. So that was.. that was a nice experience… because she, she is one member of her profession, isn't she? And if she's facing that, all of them are going to be facing that… Try not to see these things in isolation and look at the bigger picture rather than just this is one person from this thing and look at how it reflects on that whole profession..."

Beth[2]*; Interview 2*

And Beth[2] continued to consider the issue of 'camaraderie' when she talked about how she wished she had more contact with students from other professions when on placement. She said that she had only come across one other student from another profession when on placement:

"I've only seen one other.... I think she was ODP but I don't think she was from here, um, just recently on this last placement because she came to the desk and asked where to go to the theatres. But other than that, there was no interaction. And I think that was quite a... Because they're our colleagues and they're students and we're in a very unique position... We don't, you know, we don't always know what's going on and we don't always know where things are in placement. And I think there's a camaraderie in that. Um, so it would be nice to have had...some together education, I think.."

Beth[2]*; Interview 2*

Jo[1] talked about how the IPE sessions had given her a valuable opportunity to simply meet students from other professions:

"It's good to mix with other professions"

Jo[1]*; Interview 2*

5.3.4 Self Awareness

Beth[2] identified how she the IPE session she had attended had enabled her to learn about herself and the impact of her behaviours and actions on others:

"I think I learned the most about myself more than anything"

Beth[2]*; Interview 2*

She explained how during the course of the IPE session she had got involved in a conversation with another midwifery student:

"my friend and I disagreed on a point, as we often do, challenging each other and provoking ideas. … there was quite a heated discussion, um, where our voices were raised at a level that perhaps was not appropriate, um, and some language was used between… between the two of us, not in an offensive way, just in a less than professional way…which shook me. In all honesty, I didn't... Because I perceived it so wrong."

Beth[2]*; Interview 2*

Beth[2] said that she had heard that the facilitator had been unhappy with what had gone on:

"I then received feedback after the session that the lecturer had found it really inappropriate. And, um, had been quite upset by our conduct, which shook me"

Beth[2]*; Interview 2*

This had led Beth[2] to reflect on her actions and behaviours, and this made her realise how she may have come across to others, and how important it is to be aware of your conduct and how you may be perceived by others, particularly when interacting with individuals who you may not usually interact with:

"I think I thought at the time, I knew we were loud and I knew I perhaps didn't handle it as well as I should have, but that was my only perception"

Beth[2]*; Interview 2*

"I perhaps hadn't considered... the way that our behaviour was coming across to them and that we were both the loudest, um, and perhaps took control of the conversation and didn't give other people as much opportunity to speak as we thought we were."

Beth[2]*; Interview 2*

"…I think it was only when you took us out of that group that then that behaviour had a new light shone on it, and, as appropriate as that would have been in our midwifery lectures, it was not appropriate at all within this interprofessional setting..."

Beth[2]*; Interview 2*

"there's more than just us in isolation and, and the, the discourse that we're used to within our own groups, how that's not necessarily appropriate outside of those groups."

Beth[2]*; Interview 2*

Beth[2] also commented that she felt that not only were other people forming opinions about her as an individual, but they were also forming opinions about midwifery students in general, and the midwifery profession as a whole, as a result of their observations of her behaviour. She suggested that there was a concept of her being representative of her peers and profession:

"I didn't quite recognise the weight of my actions and how that would reflect on my career and my, uh, profession, I guess, and how we would look to the other professions."

Beth[2]*; Interview 2*

She also observed how this may have an effect on IPW:

"I didn't then consider… The way that the lecturer felt and the way that the other people felt and then the way that that reflected on midwifery as a profession and how that could perhaps change the dynamic within a interprofessional, um, scenario not just within university, but outside and in work.."

Beth[2]*; Interview 2*

"I .. did quite a lot of reflecting about it and my behaviour and how that looks and power dynamics and leadership and, um, inter professional relationships and how it's so important that we have respect for each other and understanding each other."

Beth[2]*; Interview 2*

It was apparent that this was a particular profound and powerful experience for Beth[2]:

"So massive learning curve on that one. Um, but still a very positive experience…. Um, so that was probably my most… My biggest experience of IPE this year"

Beth[2]*; Interview 2*

5.3.5 Race and Diversity

Following on from her discussion about race and diversity and IPE in her first interview, Amy[2] raised these issues again in her second interview. Amy[2] explained how she had started a BAME student support network within the university. This has been a result of her concerns around the attainment gap between BAME and non-BAME students. Amy[2] explained how she felt this fitted with her experiences of IPE because the groups she was working with were from many professional groups:

"On the student level, I'm working with mental health students, nursing, midwifery, social work"

Amy[2]*; Interview 2*

"not just like nurses, like midwifery, whatever course you're doing, as long as you're BAME"

Amy[2]*; Interview 2*

There were some important factors that had emerged from setting up these groups. As Amy[2] had identified, the initial aim was to address inequalities in attainment and to establish a forum whereby concerns around experiences and the attainment gap could be raised with the university and placements:

"the main thing that made me, you know, start this group was the attainment gap between the students…. because I spoke to, like a lot of people within the university like, why is this attainment gap there, you know, between black students and white students … it's like a massive gap…."

Amy[2]*; Interview 2*

"awful, awful experiences, like other health professional things, stuff that's been said to them by staff, how they're treated and how like, discrimination in the workplace, how they're always told to do like the bad jobs. And, you know, white students are not told to do the bad jobs."

Amy[2]*; Interview 2*

"[students].. come and say, you know, tell me all these experiences and then I try and relay it into practice…."

Amy[2]*; Interview 2*

"So I work with, like, the trust … I'm part of the BAME group …we'll have the phone call, a conference call ... if you have, like, any grievances or experiences that you want to share, and they can help, so you've got like practice facilitators in there. You've got like the head of the BAME group in the Trust there, sometimes you have the lead in equality and diversity, all of them that like listen to me when I bring all this feedback from the students. And they're trying to help."

Amy[2]*; Interview 2*

And it was also a forum for Amy[2] to support the students in the groups. She explained how there was perhaps a cultural issue at the heart of these BAME students' perceptions of their own achievements which she could address:

"..for them to get to realise that an action plan is not a bad thing. You know, sometimes an action plan is there to actually help you and guide you to achieve what you need to achieve. But they always looked at an action plan as like a failure. And this came for me as a cultural thing that, you know, you're not doing this right, it is wrong. And the age group … most people doing like health care courses, they're quite mature students. So it's like someone's mum or aunt and they've always grown up knowing that, you know, if you do something wrong, you get disciplined and you have to do this. So they've always looked at the action plan as they've done something wrong and never looked at it from a positive point of view. So trying to get them to look at it as like a positive, not as a negative"

Amy[2]*; Interview 2*

However, the groups have subsequently emerged as an opportunity for the students within the groups to support each other interprofessionally and share experiences:

"So we started like study groups. So initially it was just student nurses, third year student nurses. And then the first years will have their group, and then Pharmacy students had a group. But then we felt like, why not all come together? Because everyone's got different knowledge and ideas of how to do stuff, so we all come together … and then just have a day where we, like, help each other with assignments um, group work, presentations.... But then it always leads to people talking about their own experiences"

Amy[2] *Interview 2*

And through these conversations there have been opportunities to learn about each other and each other's roles, and how they perceive their profession is considered by others:

"we had a discussion on …the impact of the pharmacist in the hospital, like because the pharmacist... we always say, oh, we just need the pharmacist when we need something done with the prescription, or the doctors have come in like, you know, prescription needs updating. But the pharmacists feel like, the students feel like, oh, we're not that regarded as part of the interprofessional group…. they feel that they're not included as part of the team, more of that hierarchy like, you know, you just come in when you're needed. But they're needed all the time because patients are on medication. So you need to see a pharmacist, you know, talk to them nearly every day really. But they feel, like they don't...."

Amy[2]*; Interview 2*

And Amy[2] explained how those interactions with other professional groups have changed how she herself perceives and interacts with individuals from other professional groups:

"it's made me, like, challenge myself. When I'm working on placement, to go to the pharmacist and actually, not just go see them when I need, like, a prescription done, but actually go and speak to them and ask them questions about medication and learn from them"

Amy[2]*; Interview 2*

"when I'm on placement or working interacting with... whether it's the social workers, or the pharmacists that I actually go and communicate with them and learn from them and ... not make them feel included, but just make use of them in a way that I never thought I would."

Amy[2]*; Interview 2*

5.4 Hierarchy

As in the first interviews, hierarchy emerged as a strong issue from their experiences for all the participants.

5.4.1 Between professions

Once again all of the participants raised the issue hierarchy between professions whilst on placement. Amy[2] outlined how she felt that the hierarchy existed in practice:

"In health care, I use hierarchy as, you know, there's consultants and then it's registrars, and you've got like your F1 doctors, you've got the SHOs then you've got matrons, and then you got ward nurses, and then you've got even clinical support workers. And then you have student nurses. But then as a third year student nurse, they regard the clinical support workers as junior staff to you"

Amy[2]*; Interview 2*

Amy[2] certainly suggested that some professions were held in higher 'regard' than others and that affected their position in the hierarchy:

"You regard some people more than you regard others."

Amy[2]*; Interview 2*

The issue of attitudes of doctors seemed to be a particular strong issue for Meg[1]:

"I think definitely for some doctors it is most definitely, a hierarchical thing.. You can see it straight away and you see it, you know, you watch things happening particularly in the office, and you can see straight away - I'm in charge. You're gonna listen to what I say"

Meg[1]*; Interview 2*

"you definitely feel it from the doctors. They are quite often.. you are... they don't even look at you. They don't acknowledge you, they don't talk to you."

Meg[1]*; Interview 2*

Meg[1] offered an example of 'attitude based on hierarchy' when reflecting on the wearing of badges by staff:

"we all where badges. "Hi, my name is ...." … the doctors don't, the doctor's don't wear those badges….. that really actually kind of gets my goat, that kind of makes me feel that's a hierarchical thing.... 'I don't have to wear a badge'.."

Meg[1]*; Interview 2*

However Meg[1] further commented that this attitude shown to her may not be as a result of a perceived hierarchy between doctors and midwives, but possibly a result of the positioning of students within the hierarchy:

"But again, I think that comes down, maybe comes down to a cultural thing - It is the way it's always been done. Students are just, just a nothing."

Meg[1]*; Interview 2*

"I wasn't even acknowledged as a person in the room. It's just, it is an everyday thing, and it's quite... that makes me feel really cross that that's kind of accepted."

Meg[1]*; Interview 2*

These sentiments were echoed by Jo[1] when reflecting on an experience with a doctor, which she had already commented on in her first interview, although she was unsure if her status as a student or as a member of a profession deemed by the doctor to be lower down the hierarchy was a factor:

"I had a situation where I'd started an assessment on a patient and the ward doctor come along and rightly or wrongly felt that what he had to do with that patient then and there was more important than what I was doing. I was fine with that, I was like,"I can come back later.... It's not a problem." The patient's son went absolutely berserk and just told the doctor they were rude, they were..., you know, to the point where I was quite, quite embarrassed, um, now I see that on my part as recognising, as other professions that he's busy, that he's got stuff to do, but on his part, the son was quite right -he was really, really rude. There was no "can you come back and do this later? Would it be a problem if I stepped in?" It was I'm stepping in now, like it or lump it, so that, um, the hierarchy of that.. Would he have done it to a qualified OT? Probably. Probably would have. I don't think it was because I was a student."

Jo[1]*; Interview 2*

However, despite this experience, Jo[1] was also of the opinion that she had seen very little evidence of hierarchy between professions during her placements, however she did recognise that at times the expertise of one profession in a particular task resulted in them taking the lead:

"And I never saw any hierarchy amongst that at all, which was good. Never really saw anybody stand out and take... The podiatrists did with the castings. Um, but that's his area. The physios were there

more just to support, um, but in the other stuff that I saw, there was no hierarchy. There was no... "Our profession is better than yours or anything like that - or not that I saw anyway"

Jo[1]*; Interview 2*

Amy[2] seemed to concur with this view when she suggested that some professions did not fit within the hierarchy – that there was a sense of the transience of the role affected their status in that they were only present when their expertise was required and at that point they were considered to be very important, but since they were not present when they were not required, they were not then considered to be important:

"if you was on the ward... So you would have like the matron that comes, you've got the ward manager, You've got band sixes, band fives and then you have the support workers. And then if you was on the ward, and then you have the doctors and whatever, but all the others like, the physios, dieticians, I don't think they're like regarded in the hierarchy in the sense that they come when they're needed, but if they're not needed, you don't see them ….But then I had a day when a patient was really poorly. They probably got like a BMI of like 15 or 16 and they needed like a dietician input, and then, you know, or they had like a grade something pressure sore and they needed physio after surgery. Then the physio and the dietician are really, really important in the hierarchy…. like the needs, based on the needs for that day"

Amy[2]*; Interview 2*

Beth[2] acknowledged that there was a need for a hierarchy to enable decision making, however she also reported that from her experience that she had observed a flatter command structure than a traditional hierarchy may suggest:

"I mean, there's got to be a hierarchy, hasn't there.. there's got to be somebody who is more senior, somebody who makes the final decision or somebody that you go to for advice, there has to be that in order to work and, and to be successful… but I don't think that that necessarily comes across within the attitudes of the teams, I think, um, often times that you're just equals and it's just 'I'm asking my colleague'"

Beth[2]*; Interview 2*

And building on this concept of 'equality' Beth[2] further reported that a 'partnership' environment of co-operation was in evidence from her experiences in placement:

"It's not so much a them and us, it's a 'us altogether', which is quite nice and tends to be the majority of my experience in placement."

Beth[2]*; Interview 2*

"actually everybody has their own role and everybody has their.. within their role.. is very important and... It's like ants isn't it .. it works if everybody is working together."

Beth[2]*; Interview 2*

Beth[2] also reiterated her view from the first interviews that whist some individuals did prescribe to a hierarchy, it was not necessarily the norm:

"Some people have the 'Oh the doctor's attitude,' um, or 'Oh you need to ask the SHO' or 'Oh it needs to be the Reg because you can't go...' But actually it doesn't always transpire like that"

Beth[2]*; Interview 2*

Beth[2] again built on a point she raised in the first interview and explained that she thought that it was the responsibility of everyone, particularly those entering the profession, to ensure that concept of hierarchies which had been built up by convention and tradition be challenged in order to remove the preconceptions and attitudes that had previously prevailed:

"I can remember mentioning that actually it's our job to not do that.. And to.. and to stop, um, perpetuating these.. These ideas that people are... Better or more important"

Beth[2]*; Interview 2*

She also felt that it was only right that that there should be some recognition of another's knowledge and experience which may result in a hierarchy through respect:

"some of them are… very senior and have that air of seniority about them and .. expect the respect, I suppose, of a post like that, which is, you know, understandable."

Beth[2]*; Interview 2*

Certainly, the issue of respect for each other and the expertise that others bring with them to a situation was also important to Jo[1]:

"So there shouldn't be a hierarchy, there should be respect for one another's profession. There should be respect that a consultant has trained, what, seven years plus to get where they are. That respect should come automatically, you know, doctors as well, that respect should be there. But then they also need to show their respects of maybe an OTs knowledge of OT is actually stronger than their's"

Jo[1]*; Interview 2*

She explained how she had observed this respect for her own profession shown by staff from other professional groups whilst on placement on the ward:

"I was actually pleasantly surprised at the respect that the wards had for OTs. Um, basically. A client or patient couldn't be discharged without the OT saying so. So you'd have to have to have the consultants to say they could go home, the nurses to say they could go home and finally the OTs to say they could go home. So there's a lot of respect for the OTs on the wards…"

Jo[1]*; Interview 2*

Jo[1] was also of the view that the banding system of employment within the NHS contributed to making this possible:

"I think actually the banding helps with that, the NHS banding, I do. Um, because, you know, if you've got two people ones a physio and ones an OT, and you're both band 6, you kind of see yourselves at the same level anyway".

Jo[1]*; Interview 2*

An interesting point came from Amy[2]'s recollection of her discussions with the physician's assistant whilst in India. She had already acknowledged that she had learnt about the role of the physician's assistant from these discussions, however when suggesting that the physician's assistant could be a nurse it is possible that she was making some sub-conscious judgements on the status of the physician's role:

"and the knowledge that she had. Based on the knowledge that I had and I would say to her, you know, oh my God, you should definitely go to nursing school because you've got all this knowledge and I don't even know half the things that, you know."

Amy[2]*; Interview 2*

5.4.2 Cultural Factors

In Amy[2]'s case, her experiences in India clearly had an impact on her thoughts regarding hierarchy. She acknowledged that in the UK she was used to an element of professional hierarchy:

"when I'm at home here, there's things that I don't even think about, you know, like things like, well you do consider it, like hierarchy, but it's hierarchy professionally like, you know, the doctors and then maybe dietitians or nutritionists and the nurses."

Amy[2]*; Interview 2*

And like Meg[1] she commented on the position of students. However, unlike Meg[1] she was of the opinion that from her experiences of placements in the UK students are valued:

"Here, I'm a student and when I go and work in the hospital, even though I'm a student my point and opinions, and they're still valued and people still consider me as part of the team"

Amy[2]*; Interview 2*

However she contrasted that with her experiences in India:

"you take things for granted because when here… when I go on placement and I'm working with different people, even though I'm a student, if I ask questions, you know, my questions are always answered. People always willing to teach me because, you know, they're like, you know, you're part of the team. Even though you're a student…they want to educate you…. whereas when I was in India, it was more of, you know, you're a student, you don't know anything."

Amy[2]*; Interview 2*

This made her appreciate how she was treated as a student in the UK:

"it just made me feel like... Well appreciate one for being a student here"

Amy[2]; Interview 2

But even when reflecting on her experiences in India, there was a recognition that this feeling towards students was not universal, and although she felt she was not regarded or valued highly by staff in the private hospitals, in the public hospitals she was received differently:

"Whereas when I went to work in the like slum clinics, the GPs, the nurses and other doctors, they were welcoming and the communication was really good. They would, um, they were willing to teach you … whereas in the private hospitals it was a bit of ... just stand and watch. You're not allowed to do anything.."

Amy[2]*; Interview 2*

Amy[2] also reported how she found that cultural factors were evident in the established hierarchy in India, as a result of gender:

"like as a woman….how they regard women in India is totally different to when you're at home and how, you know, you could have a male nurse and a female nurse, but the male nurse is always, you know, higher"

Amy[2]*; Interview 2*

And she reflected on how this often created some rather challenging situations when it came to a perceived conflict between professional standing and gender:

"if let's say the doctor was male and all, everyone else on the staff was female, they would always expect everyone else to come and report to them. But if the doctor was, female you know, and everyone else was male. The males always expected her to then come and communicate. But because this whole thing with hierarchy and she feels like she's in charge of it...Well, I'm going to wait for you and you're going to wait for me.... And then nothing happens. And then the patients wait...."

Amy[2]*; Interview 2*

Race was also an issue raised by Amy[2]. This had already been identified as an issue in her first interview, and certainly emerged from her experiences of her placement in India. She referred to the reaction she had from patients:

"but the patient looked at me as .... compared to let's say another student, as a student from England... they're white, I'm black…. And the patient automatically goes to the white student."

Amy[2]*; Interview 2*

And from staff:

"And then the doctor would see me and would be like... What's your name? Where are you from, you know, are you a medical student or nursing student? And you'd say, oh, nursing student. And they'd say, oh, OK... And then you'd sit in his office for maybe like 10, 15 minutes and he'll come back and go 'I've really have got quite a busy list today,' I'll hand you over to someone else and they can come... And and you'd sit there and then I had to, like, proactively go and find someone to say I've been waiting in his office for like half an hour. Can someone tell me what to do? And they'd be like Oh I'll take you to the nurse and then the nurse would say Oh, I thought you'd be working with the doctor and I'd say, oh, the doctor said he's got a big list, and she was like oh he's worked with this other nursing student yesterday or, you know, and you'd think oh OK then"

Amy[2]*; Interview 2*

"So I was like, you know, I'm not getting treated professionally how I expected to be treated. But then it's now then gone on to a personal level where, like, my race is an issue. So then it's been both professionally and personally. So it was difficult, but it was a good experience because it then made me aware that, you know, some things that you just take for granted, like, you know, you walk into a hospital and everyone's like 'Oh hi', and everything's fine because I've never faced that discrimination here."

Amy[2]*; Interview 2*

And she felt this discrimination was amplified by her position as a student:

"But you're still the student and you don't know anything... And then you're not just the student. You know, you're the black student."

Amy[2]*; Interview 2*

5.4.3 Challenging Hierarchy

As in the first interviews, the participants once again commented on the issues of challenging hierarchy. Meg[1] talked about how she felt it was extremely difficult to challenge hierarchy:

"I think it's only the most confident midwives and the most assertive midwives who will challenge certain situations."

Meg[1]*; Interview 2*

And she went on to describe a situation when a midwife had challenged a consultant and was reprimanded – which gave Meg[1] concerns about the working environment she was about to enter into:

"But the midwife really stood her ground. And later on when I spoke to her, she said.. She said.. I said are you all right. She said she just got the biggest bollocking back in the office from this consultant because she wasn't happy. And I just thought, oh, my God, you know, that's, that's really awful. That's ..this is what I'm going into."

Meg[1]*; Interview 2*

Likewise, Jo[1] described a similar situation where a physiotherapist had challenged a consultant:

"I did witness the physio that I worked alongside, um, very experienced, in fact she was coming up for retirement, I believe she was, I mean, she was a band seven, but had been a band 8 in the past. Um, and she was really, really strong with one the consultants, who wanted to send a patient to neuro rehab, and she was why, like "Why there is no evidence they will not accept her." And in the end, she said, look, I'm going to wash my hands of this. If you want to refer the patient, refer the patient, but I'm telling you, they will not accept her. And lo and behold, two days later, the referral was sent back and they didn't accept her. And the consultant was quite rude with the way he spoke to her.."

Jo[1]*; Interview 2*

How she was treated was clearly important to Amy[2] in that it affected how she engaged in the placement:

"And because you don't feel like you're wanted there, then it just makes me, makes me detach…"

Amy[2]*; Interview 2*

However, reflecting on her experiences in India, Amy[2] seemed resigned to the fact that any individual may not be treated the way that that they might expect, because expectations may vary:

"it made me realise how you're not always going to be treated, how you want to be, you know, how you expect to be treated, because, you know, everyone has their own expectations of how they should be treated personally"

Amy[2]*; Interview 2*

And this issue of personal expectations was encapsulated when Amy[2] recounted a discussion she had had with an Australian student who was on the India trip. The student was in the navy and had a different perception of hierarchy which affected her expectations:

"it didn't really affect her as much as it affected me because she's like, well, I know my place. You know, I'm just like on my second year. These people have been here for like two years, 10 years, 15 years, 30 years. You know that whole hierarchy thing that you have to respect it when you're like in my profession, you know, there is that respect. I guess we're all here to achieve that. You know, the same goal. But you're still a junior, so, you know, you're learning. So the whole hierarchy thing didn't affect her. But I would say to her, Yeah, but when we're at home, you know, even though I'm a student nurse, I can still talk to the patients, the patients would tell me what the problem is. I would go and relay it to the nurse and the nurse would actually rely on what I say to her so she can do her job. So I'm still a part of the team, there isn't that whole thing of Oh, she's just a student, so I was finding it difficult. But then she didn't."

Amy[2]*; Interview 2*

Certainly, this allowed Amy[2] to question the reasons behind her views on how she should be treated and regarded by others in her role as a student nurse:

"…it made me understand in a way, maybe, because I thought maybe am I being a bit too much with this whole like, I want to be treated on the same... you know, we're all health professionals. I'm a

nurse, I'm a student but I'm a nurse… it made me look... um.. things like to take a step back and then just look to see like… So it just made me realise that, you know, the hierarchy is ... it's got a different, like, not a different meaning... But like when it comes to different professionals, everyone takes it differently to maybe how we take it in, like, health care"

Amy[2] *Interview 2*

So it seemed as if the expectations of how one should be regarded and treated was linked to professional role – with Amy[2] proposing that students on health care programmes could expect to be treated in a certain way because they were part of a profession that had its own standards of conduct and behaviour:

"I just felt like in health care, yes, there is hierarchy, but …. I'm an advocate, you know, that's what I kept saying to her, you know, I'm also an advocate the patients."

Amy[2]*; Interview 2*

5.5 Facilitation

Once again, as in the first interviews, the influence of facilitation on their experiences emerged from the second interviews with the participants. Issues highlighted included the organisation of the sessions and the attitudes and conduct of the facilitators themselves.

5.5.1 Organisation

Jo[1] repeated what she had said in the first interview that how interaction between the professions was not encouraged in the sessions when she thought it should be:

"We…went to the classroom, we all sat in our groups. And never, not once in three years have we been encouraged to mix. Not once, and I find that quite strange."

Jo[1]*; Interview 2*

"I think it could be encouraged by the lecturer to say, OK I see you're all comfortable in your groups but it would be great if we could make this up for you to have a chat with who's next to you, find out what their role is... Just find out something you didn't know about their role."

Jo[1]*; Interview 2*

"even in the first year…we was told not to worry about mixing of groups for a presentation because she knew it'd be hard for us to find the time to all meet. So just to stick with your own, which kind of defeats the whole object…"

Jo[1]*; Interview 2*

For Amy[2], there was an issue of organisation of IPE, in that she felt there were not enough sessions dedicated to IPE in the timetable:

"I feel like there needs to be more days because I feel like there is a lot to learn. But cramming it in one day is not enough? I feel like it has to be, not like a module, but maybe once every, I don't know... to just have a bit more to, like IPE days to just get people to have, talk about experiences and how to implement them"

Amy[2]*; Interview 2*

5.5.2 Role of Facilitator

Again, the participants also expressed how crucial the role of the facilitator played in their experience of IPE.

Jo[1] reported that the facilitator for her IPE sessions this year had been very good which affected her experience:

"The lecturer was fantastic. She was really good. No problems there"

Jo[1]*; Interview 2*

"year three, I found the lecturer to be the strongest."

Jo[1]*; Interview 2*

For Meg[1], what was important was the attitude of the facilitator. She repeated the concerns she had expressed in the first interviews about how the facilitator had spoken to the class:

"There was some. Unsettlement... can I say that the presenter who was talking to us that day told us ... we were told not to email our tutors and not to ask for feedback, not to ask them to look at any of our drafts or anything because we would not get any feedback."

Meg[1]*; Interview 2*

"You just felt.. Like, if you had a question and if you weren't sure, well it was kind of tough luck, you know, you've just gotta to get on with it., definitely for me, I was taken aback.... Oh don't, don't, don't ask for help. You're not gonna get any... And I don't think maybe that's necessarily how it was meant, but it's certainly how I came across in that situation. And a lot of people were really confused."

Meg[1]*; Interview 2*

"I think it just felt a bit like the rug being pulled out from underneath us."

Meg[1]*; Interview 2*

Meg[1] compared this to the way in which the modules of her midwifery programme are facilitated:

".. from the midwifery ….there's a lot of support and we email them and ask them questions and all.. we always get to email a draft … So that gives us reassurance that we're not going to write something that is completely irrelevant. And then we were told this. And I think that kind of upset a lot of people because we then felt that there was no support there. We just felt like, OK, here's this, go away and write it ...so I think we just felt out on a limb in a way"

Meg[1]*; Interview 2*

In a similar vein, Jo[1] observed that the knowledge held by the facilitator of the variety of professions represented in the group was crucial. She felt that the facilitator during the previous year's CP session had shown a lack of knowledge which undermined her confidence in the process:

"I got a comment on my feedback. I wouldn't say it was sarcastic as such, basically. it read: You don't appear to know whether you're 'royal' or not. That's what it said. Now, with some of the... Because we've only changed over in 2014, a lot of the literature that we reference is just is COT and then some of it RCOT. So that was a lack of knowledge on the lecturer's part. Which again, I think goes to show. The lack of knowledge of our profession, I just thought, it's quite ironic when it was collaborative practice."

Jo[1]*; Interview 2*

Jo[1] also echoed her observations made in the first interview and expressed the importance of continuity of facilitation*:*

"This is what happened to us in year 2…we had somebody different for all the other sessions. So you kind of, It's like "What's actually wanted for this assignment", because when that lecturer was here, they said one thing. This lecturer said something slightly different. That's okay. We'll check it out at the next session. Whoa? We can't, because it's a third different lecturer."

Jo[1]*; Interview 2*

And Meg[1] described similar experiences:

"there was quite a bit of inconsistency with the teaching staff. And I get that's due to illness and things, sometimes, but I think... I don't know, I think it's a kind of an awkward module - they don't know us - if I walked past one now they wouldn't know who I was at all... if the lecturers knew you more …. it would bring it together in a better way. They would have a better understanding of our learning needs and learning styles and how we do things"

Meg[1]*; Interview 2*

Meg[1] explained how she had not attended a session because the lecturer was going to be someone she had not been taught by before:

"I didn't go to the last lecture because I was emailed in advance to say that the tutor we were going to have, she wasn't going to be there, and somebody else was going to be there... And I honestly just thought, I don't know if there's a point in going, I don't know what I'm going to get out of it…. I just felt it wasn't worth a trip to come...may as well stay at home and crack on with writing"

Meg[1]*; Interview 2*

And as in the first interview, Meg[1] identified the methods of delivery of the session as being crucial to her experience:

"I think doing practical things as well, like working in the skills lab together and having scenario based situations and getting groups of students together to go 'right OK... What would we do in this

situation, how could we manage it, how would we need to think about the other's roles and what they're going to do"

Meg[1]*; Interview 2*

"I think we all enjoy the clinical, you know, the placement side of it, because that's what we want to do. And that's our end goal. And not all of us are amazingly good at academic stuff ...when you can relate it to a particular scenario or a learning experience that's practical... I think you can really draw a lot down from that, especially if you're going to write an essay, rather than just sitting in a classroom and learning like that.."

Meg[1]*; Interview 2*

Jo[1] also reiterated her comments in the first interview that the delivery of the taught IPE sessions had affected the attendance at the sessions by the student group:

"Year One fabulous … I think in year 1 people are probably more eager anyway…. so you turn up, by year 2 you realise that, actually, somebody was off for three weeks and didn't get noticed, so. I think… you become a little bit more lax anyway, um. But had, had the interest been there, people would have engaged, I fully believe, because that's been proven … if it's a lecturer that's really well liked and if the subject is really good, it's a full class. If it's something that's a little bit harder, a little bit more theory driven, a little bit more "have I really got to do is", um. You know, you do get less people turn up."

Jo[1]*; Interview 2*

This was also an issue that was commented on by Meg[1]:

"it's just maybe how we go about it to make sure people engage more, because I know from going to the sessions myself, the attendance is low. And, you know, you go into the first session at the beginning of the year and the classroom is full, and by the end of the year there's ten, fifteen people there and you know, there's thirty there on the roll."

Meg[1]*; Interview 2*

For Meg[1], engagement with IPE was clearly a concern. She seemed to place a high value on the concept of IPE, but was worried that there was a lack of engagement in IPE at all levels, or a lack of enthusiasm to engage in IPE at all levels:

"The engagement thing is shown at my level, at student level, but then it's also actually at the level where once people are qualified and even when they're very high up the chain and I think probably people who are very high up the chain are probably less likely to engage"

Meg[1]*; Interview 2*

And this means that the positives which may come out of IPE were not materialising:

"… that's the solution, isn't it, is to bring people together and go 'right these are the problems, we need to look at how we can overcome them and how we can work better together. But the problem then is engaging those people, because I know it's … training, isn't it? And it's also whether people

want to engage in that, because people do that lip service thing "Oh yeah I'll go to training. Going to sit there for two hours and get my certificate, and then walk out and continue to practice same as I have been, and I don't know how you overcome that."

Meg[1]*; Interview 2*

Jo[1] also suggested that there was some real positives to be gained from staff of all levels engaging in IPE, but there was a lack of a willingness to do so:

"I think it needs to be taught in the workplace. I think... It's probably never going to happen... but I think consultants should be on that same training with physios and with OTs"

Jo[1]*; Interview 2*

"you're not going to get them to do it at that level, I don't think, although they could certainly use it, without a doubt..."

Jo[1]*; Interview 2*

For Amy[2] there was also an issue that for BAME students, it was important to be able to see facilitators from non-white backgrounds, in order to be able to feel that the staff understood and appreciated their experiences, and had perhaps experienced similar things themselves:

"..it's like interprofessional education, interprofessional experiences, but as BAME students like not ... you don't feel represented within the staff, especially here.., where you don't have the BAME staff as much as, like the white staff. And then you feel like if you have all these experiences that we go through... Uh, you don't have someone that looks like you to say to you, like, I've been in this situation and this is how I dealt with it."

Amy[2]*; Interview 2*

5.6 Perceptions of IPE

Amy[2] seemed to place a high value on IPE, and talked about the positive effects that IPE can have:

"And then I also got to see how, like, the effects of .... like the impact that the interprofessional education has, because sometimes, you know, when you do something and you don't really.... you think you're just doing it because it's part of education, and you have to do this module or class. But then I actually got to see the impact of it. Like when it fails, like when there is no interprofessional collaboration, like how it impacts people, like especially like in care, like with patients, the impact it has on patients"

Amy[2]*; Interview 2*

For Amy[2], the interprofessional experience in India had been an opportunity she fully appreciated. Although it was at times challenging, Amy[2] seemed to be acutely aware of the learning experience that her trip had provided:

"an experience abroad is a good thing for all students, because they may be like in health care regards of nursing, medicine or social work…it makes you.. It takes you out of the bubble that your in, and know…. it opens your eyes of the privileges that you have"

Amy[2]*; Interview 2*

Meg[1] also seemed to put a high value on IPE:

"There is completely a place for interprofessional working and, you know, teaching it and learning it and exploring it more, it's needed, isn't it?"

Meg[1]*; Interview 2*

And this was reiterated by Beth[2]:

"I'm aware of the other benefits of IPE, of building relationships and breaking down these these hierarchies and creating better teamwork and better understanding of everything"

Beth[2]*; Interview 2*

Likewise Jo[1] was of the opinion that IPE played a role in 'normalising' and encouraging collaborative practice and IPW, and that it should be embedded at all levels of education:

"I do think it needs to be taught from this stage at university, maybe even on….health BTECs in health studies and stuff, maybe even at that level, um, sort of as grassroots as possible so that it becomes the norm, which I don't think it is. Yet, that's how it needs to be... That it's just normal, just normal to work alongside a paramedic"

Jo[1]*; Interview 2*

5.7 Summary

This chapter presents the results from Interview 2 with participants in this study. As in Chapter 4 The results were presented by the themes which emerged from the interviews. An overall analysis of the outcomes of the interviews and a discussion of the findings in a broader context relating to the published literature will follow in chapter 6.

6.0. Chapter 6. Discussion

6.1 Introduction

This chapter engages with findings of the literature review, results and analysis of the study to provide a discussion on the themes that have emerged. Again, for the clarity of the reader, the two students who followed the 2012 curriculum (Meg and Jo) have been annotated as Meg[1] and Jo[1] and the two students who followed the 2017 curriculum (Amy and Beth) have been annotated as Amy[2] and Beth[2]. The discussion is divided into seven sections; defining IPE; learning with, from and about others; communication and teamwork; facilitation; hierarchy, status and power; self awareness; race, diversity and inclusion.

6.2 Defining IPE

Earlier in Chapter 1 it was explained how IPE is defined in several ways in the literature, with the most cited and accepted being that of CAIPE (2017); "occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services". IPE is specifically defined by the involvement of members (or students) of more than one profession. Conversely Intraprofessional Education is defined by the involvement of individuals within the same profession but different grades or specialisms (Teheux et al 2021). It was interesting to note that during the course of both sets of interviews, the students in this study associated IPE as working with both qualified staff and students from their own and other professional groups and therefore did not make any distinction or differentiation between Interprofessional Education and Intraprofessional education. This therefore suggests that considerations of definitions may warrant re-examination.

6.3 Learning with, from and about others

Having the opportunity to mix with students from other professions has been raised as an important aspect of IPE by a number of authors (Telford and Senior, 2017; Allen et al, 2014; Osman, 2017 and Roberts and Goodhand, 2017, Hallin and Kiessling, 2016). Hallin and Kiessling (2016), Telford and Senior (2017) and Osman (2017) concluded that participants in their studies valued and enjoyed working with people from other disciplines during IPE activities and that this contact was beneficial to preparation for clinical practice. Derbyshire and Machin (2011) reported how participants had valued opportunities to learn in small groups with a mix of different professions represented and concluded that IPE opportunities in small interprofessional interactive groups were acknowledged as the most effective learning and teaching approach. Findings from this study would concur with the general view that the concept of having contact with students and professionals from different

groups positively affects how members of other professional groups may be perceived and can improve working relationships, both in the present but also possibly in the future. Jo[1] stated it was 'good to mix with other professions' (Jo[1]*; interview 2 p 77*), Meg[1] suggested that contact with students and qualified staff from other professional groups 'humanised' other people and this would benefit working relationships (Meg[1]*; Interview 1 p 49*). She also talked about how having an interaction on a social level with someone from another profession would positively affect how she viewed others from that profession. This was echoed by Beth[2] who recounted a similar experience during interview 2 (Beth[2]*; Interview 2 p 76*). Likewise, Beth[2] talked of how it was 'nice just to have a conversation and to appreciate the journey that everybody else is on' (Beth[2]*; Interview 1 p 45*). This resonates closely with the findings of Roberts and Goodhand (2017) who found that students appreciated the 'social situation' that the IPE experience facilitated and talked of how being able to just 'chat' with others had helped break down barriers between professions and also helped them to overcome stereotypes.

Further to the importance of IPE enabling contact with others from other professional groups, learning from, and about others has also been identified as an important aspect of IPE. Whiting et al (2016), Roberts and Goodhand (2017) and Derbyshire and Machin (2011) have all found that IPE gave students further insight into the roles and responsibilities of others. Roberts and Goodhand (2017) commented on students developing respect for each other's profession and their role, as a result of the IPE activity and Whiting et al (2016) suggested that studying with peers from other professional groups helped to avoid 'misconceptions about what others do'. Participants in this study expressed mixed feelings around this issue. Beth[2] talked about how her experience of IPE had allowed her an insight into the role of others (Beth[2] *Interview 1; p 42*) and Meg[1] and Jo[1] thought this was one of the fundamental purposes of IPE. However, both Meg[1] and Jo[1] were of the opinion that their IPE experiences had only enabled an understanding of the roles of others to a limited extent (Meg[1] *&* Jo[1] *Interview 1; p 43*). For both, this appeared to be as a result of facilitation. Derbyshire and Machin (2011) highlighted in their study the importance that participants placed on having students from other 'relevant' professions participate in the IPE activity, and in this study Meg[1] expressing frustration that the people she had been asked to work with in the classroom IPE sessions were from professions that she did not work with, and so she did not have the opportunity to learn about the roles of those that she did (Meg[1]*; interview 1 p 43*). In her first interview, Jo[1] said she felt that there were not enough opportunities to share information with the group she was in during her IPE day. Interestingly, however in the second interview Jo[1]'s opinion seemed to change as she explained that the 'realisation' of others roles had been one of the most positive aspects of her experiences of IPE, and went on to say that without the interprofessional element of the

programme, she would have had little opportunity to learn about the roles of others since she felt other professions were rarely talked about in her OT programme (Jo[1]*; interview 2 p 69).* This suggests that at some point between interview 1 and interview 2, Jo[1] had had an opportunity to enter into further discussion of roles in an IPE activity. Facilitation of IPE is a subject which was raised more generally in the literature and in this study and will be discussed in due course.

In her second interview, Amy[2] outlined how she felt that her programme had included opportunities to learn about others, although she was also concerned that the learning on the programme itself did not do enough to develop an understanding of others roles. Without this, there would be a perpetuation of a lack of understanding about others roles: (Amy[2]*; Interview 2 p 71*). However Amy[2] was clear that IPE gained as a result of her trip to India had enabled her to understand others roles by putting her into contact with students from other professions being placed in areas she would not normally be placed in (Amy[2]*; Interview 2 p 72*).

The concept that IPE providing a facility to allow an insight into the experiences of others – 'what they're going through' – emerged quite frequently in this study. The idea of a realisation and understanding that other students and health professionals face challenges, both different and similar, seemed to suggest an element of common ground that could allow individuals from different professions to see something of themselves in each other. This resonates with Clancy's (2020) proposal that IPE activities have a role in humanising healthcare and promoting connection across professions.

Beth[2] talked about the issue of 'silo' working and was clearly concerned about a tendency for professions to be inward looking. She offered the view that IPE gives an opportunity to be more outward looking (Beth[2]*; interview 2 p 72).* This finding mirrored that of Roberts and Goodhand (2017) who reported that participants in their study highlighted how being enabled to mix with students from other professions helped take them out of their professional 'silos'. Jo[1] and Meg[1] talked about how they had learnt about others' roles, from placement rather than classroom-based experiences (Jo[1] *&* Meg[1]*; interview 2 p 71*). Both Beth[2] and Meg[1] in their first interviews referred to 'the journey' that people go on (Beth[2] *&* Meg[1] *Interview 1 p 45*), and how through talking to individuals from other professions they can learn about these journeys, understand the challenges others have to face and overcome, and realise where these are similar to their own. The words used by Beth[2] when she said that an increased awareness of others roles could lead to a "less of a them and us. It would be more just us" (Beth[2]*; Interview 1 p 46*) indicate how important this is to her.

In the same vein as providing an opportunity to learn from others about their role, IPE has been identified as providing an opportunity to enable individuals to enlighten others about their own

roles. Whiting et al (2016) have previously highlighted students reporting that explaining their own roles to others generated a change in the view of their own profession – resulting in a more positive perception and an increased pride, whilst Osman (2017) reported that the medical students in their study felt that IPE enabled them to gain more of an awareness of their own role. These observations resonate with the findings of this study. For Jo[1], the opportunity to inform others about her profession was clearly very important. In her first interview she suggested that the role of the OT was perhaps not well known and she enjoyed the opportunity to inform others (Jo[1]*; interview 1 p 42*) and returned to this in her second interview (Jo[1]*; Interview 2 p 75*). Likewise, Meg[1] talked about how it 'works both ways' (Jo[1]*; Interview 1 p 45*) and how others understanding her role was as important to her as her understanding others' roles. Amy[2] explained in her second interview how her learning about others had gone one step further, in that during her visit to India she had been able to pass on some of the knowledge and skills she had learnt from a friend who was a Learning disability nurse to staff in the children's nursery (Amy[2]*; Interview 2 p 73*).

6.4 Communication and Teamwork

A number of studies have highlighted the effect of IPE on improving communication and teamwork. Domac et al (2015) reported evidence of the students developing communication skills as a result of engagement in IPE. Afseth and Paterson (2017) suggested improved teamworking amongst their participants and participants in Derbyshire and Machin's (2011) study reported improved ability to communicate with other professionals because of their IPE. In this study Beth[2] recognised that IPE had helped to improve her own communication skills and abilities to work in a team (Beth[2]*; Interview 1 p 47*) and stated that she considered one of the benefits of IPE to be building relationships and creating better teamwork (Beth[2]*; Interview 2 p 94*). Amy[2] referred to the importance of IPE promoting the concept of breaking down barriers between individuals and 'encouraging teamwork' (Amy[2]*; Interview 2 p 75*).

But it is the result of this teamwork which is important – and that is the outcome of a benefit to the service user. Kelley and Aston (2011) and Roberts and Goodhand (2018) highlighted how students reported an increased awareness of the importance of good communication and how effective communication and collaborative working contributes to better patient care. Whiting et al (2016) proposed that patients benefitted from a collaborative approach to care, and that as a result of IPE, students in clinical practice were more likely to suggest the referral of a patient to another professional. Participants in this study did seem to offer opinions which concur with these propositions - Jo[1] talked about 'different setting, different pathways or different professions, but all with the same goal' (Jo[1]*; Interview 1 p 47*). There was also an acknowledgement from both Beth[2] and

Jo[1] that a fundamental benefit of teamworking was an ultimate improvement in outcomes for the service users. Beth[2] suggested that healthcare professionals having personal connections benefitted the service users, and that IPE was a way to make these connections (Beth[2]*; Interview 1 p 49).* Jo[1] recognised that IPE could play a role in understanding the value of shared goals and outcomes by stating 'one thing I have learned is that regardless of anybody's attitude or opinion about another pathway, we all have the same goal, which is ultimately to help or improve somebody's life' (Jo[1]*; Interview 1 p 47*).

6.5 Facilitation

One of the most significant influences of their experiences of IPE cited by the participants in this study was facilitation. All of the participants raised the organisation of the sessions and the attitudes and conduct of the facilitators as being important issues. The value of facilitating students to mix with students from other professions has previously been raised and Telford and Senior (2017) and Osman (2017) amongst others have reported how contact with people from other disciplines is beneficial to preparation for clinical practice. In this study Beth[2], Amy[2] and Jo[1] expressed the importance of seating arrangements to encourage interaction between the professions. They explained that without seating plans, students from each profession tended to sit together and there was no mixing. However, when seating plans were provided people were 'forced' to mix and mingle which enabled them to meet people from other disciplines (Beth[2]*,* Jo[1]*,* Amy[2]*; Interview 1 p 59 & 60).* In the second interviews the participants returned to this theme. Jo[1] explained how she felt that the facilitators should have encouraged mixing in the sessions which would have enabled people to talk to others. In fact Jo[1] reported that students were explicitly advised not to worry about mixing of groups for a presentation as it would be hard to find the time to meet. They were advised to 'just to stick with your own', which she felt defeated the 'whole object' of the exercise (Jo[1]*; Interview 2 p 89*). This reported failure by facilitators to encourage mixing by the students in this study is of concern as it is at odds with the general consensus that students appreciate and benefit from the opportunities IPE provides to interact with others from other professions. Participants in Derbyshire and Machin's (2011) study reported how they had valued opportunities to learn in small groups with a mix of different professions represented, Osman (2017) and Telford and Senior (2017) reported students described enjoying previous experiences in which they worked with a good mix of professionals, and Osman (2017) observed that where medical students engaged in activities where there was only small numbers of students from other professions involved the students felt these offered little benefit over uniprofessional experiences. Poor mixing or balancing of students can have a negative effect on students experiences of IPE with Telford and Senior (2017) reporting feelings of isolation expressed by students when they were the only student from their profession in

a group, Courtenay et al (2103) reported a nurse prescribing student feeling intimidated when she was the only nurse placed in a group with eight medical students and Hallin and Kiessling (2016) reported students feeling that a team missing a student profession felt incomplete and conversely where a team was dominated by one profession this resulted in issues relating to that profession taking precedence over others and students from the dominant profession having less opportunity to practice their role.

In terms of amount of time dedicated to IPE, a number of studies have previously suggested that students would like more. Of course the term 'more' is relative and so needs to be contextualised. Students in Wright et al's (2012) study had a single half-day shadowing visit and proposed that repeated or more lengthy opportunities could provide more insight into working with others in a healthcare setting. Similarly, participants in Osman's (2017) study were of the view that there should be multiple interprofessional events throughout their undergraduate course. Kaldheim et al (2021) reported students requesting interprofessional simulation based learning to be scheduled more frequently and regularly throughout their programme. In this study, in both her first and second interviews Amy[2] felt that there were not enough sessions dedicated to IPE in the timetable (Amy[2]*; Interview 1 p 65 & Interview 2 p 89*), and likewise Beth[2] highlighted a wish for more IPE in her first interview (Beth[2]*; Interview 1 p 66*), with both indicating that these could be spread out more throughout the curriculum. It is interesting to note that Beth[2] and Amy[2] are from cohorts that followed the 2017 curriculum where 'formal' IPE involving all students from across the faculty was limited to one 'core day' per year. In agreement with the participants in Wright et al's (2012), Osman's (2017) and Kaldheim et al's (2021) study, the fact that they both indicated a desire for more IPE suggests that isolated events are not enough. Amy[2] suggested that she would like to have a module dedicated to IPE (Amy[2]*; Interview 1 p 66*).

However, Meg[1], Jo[1], Beth[2] and Amy[2] all had broadly positive attitudes to IPE regardless of which curriculum they were following, with all seeming to express an understanding of the value of IPE, and talking about the positive effects that IPE can have. These effects included encouraging and enhancing collaborative practice and improving outcomes for service users. Beth[2] in particular talked about how IPE can help build relationships between individuals from different professions, break down hierarchies and create better teamwork and better understanding of each other (Beth[2] *Interview 2 p 94*). These views mirror those already expressed by participants in studies by Roberts and Goodhand (2018) and Domac et al, (2015) amongst others.

Despite these positive attitudes to what IPE aims to achieve, Meg[1] and Jo[1] who following the 2012 curriculum seemed to have more negative attitudes to IPE in terms of their own experiences. Meg[1]

explained that whilst she felt her attitude to IPE was quite positive, her own experiences hadn't been good. Likewise, Jo[1] explained that she felt let down by the delivery of a subject which she had thought she would find interesting and stimulating. For Jo[1] this was partly down to the timetabling of the sessions, with them being spread over the year with large gaps in between. She felt that having the sessions so far apart did not enable her to get to know the lecturers and there was no 'flow' (Jo[1]*; Interview 1 p 66*). In fact Jo[1] suggested that by spreading the sessions out, IPE as a concept lost credibility (Jo[1]; *Interview 2 p 67*). The views of Jo[1] and Meg[1], who experienced IPE in three activities scheduled throughout the year may be suggested to echo those of participants in the study by Telford and Senior (2017) who also reported that timing and frequency of IPE sessions was a potential barrier to the success of IPE. Participants in their study felt that the spacing out of the events allowed students to disengage, although the spacing was different (2 hours a week over 3 weeks) to the schedule experienced by Jo[1] and Meg[1]. Similarly, the views of Beth[2] and Amy[2] wanting more IPE events, having been limited to one formal event per year, resonate with the opinions of participants in the study by Wright et al (2012). In the same vein, participants in Osman's (2017) paper discussed timing for IPE events, and the general consensus seemed to be that there should be multiple interprofessional events throughout the undergraduate course. So the design of the delivery of IPE seems to be a big factor to the participants – particularly highlighted when considering views of the participants who have had the IPE delivered in different ways. It seems therefore that there is a balance to be reached somewhere between the approaches adopted in the 2012 and 2017 curricula with regard to delivery and scheduling.

What appeared to be significant to all the participants in this study was the role of the facilitator, and in particular the attitude of the facilitators. Jo[1] commented on how what she perceived to be a good facilitator for her IPE sessions had led to her experience being a positive one *(*Jo[1]*; Interview 2 p 90*) The attitudes and the actions of the facilitator were crucial in Meg[1]'s experience and she felt were the fundamental reason why she felt she had a negative experience. In her first interview, she pointed out how there was a significant difference in attitude of the facilitators she had in her first year and second year. Whereas the facilitator in her first year had seemed enthusiastic and therefore encouraged engagement from her and the students in the group , the facilitator in her second year appeared less enthusiastic and gave the impression of IPE being simply something that had to be done and 'ticking things off a list' (Meg[1]*; Interview 1 p 60*). Whiting et al (2016) have previously reported that their study revealed the lecturer role to be fundamental for the support of student learning, and the importance of facilitators in engaging with students. Stephens and Ormandy (2018) have talked about the importance of a learning alliance within the group which stretches to the relationship that students have with their facilitator. The value of this 'learning

alliance' may be evident from Meg[1]'s experiences. During her first interview, Meg[1] was particularly disappointed in the way that the IPE sessions had been introduced. She commented on a poor choice of words by the facilitator in the introduction which had disengaged her before the module had started (Meg[1]*; Interview 1 p 61*). For Meg[1], facilitation was important because it clearly impacted on her engagement with IPE. Where she felt facilitation was poor, she acknowledged that her engagement was in turn likely to be poor. Conversely where she felt facilitation was more positive, she was more engaged and viewed the activity in a more positive way, as was evidenced in her reflection on the voluntary multiprofessional IPE study day she attended (Meg[1]*; interview 1 p 62*). It is also interesting to note how Meg[1] acknowledged the influence of her own behaviour on her engagement, and how this was affected by how she perceived the facilitation. She described a situation where she reacted to poor facilitation 'like a teenager' in terms of immediately viewing the activity in a negative way which then correspondingly reduced her motivation to engage on an ongoing basis. It is also important to note how Meg[1]'s perception of facilitation and attitude to teaching was informed and affected by virtue of the fact that she was a former teacher herself. How she expected teachers and facilitators to behave, her attitude to teachers and facilitators, and her attitude to the teaching and facilitation itself, will have been directly influenced by her own experiences as a teacher.

Telford and Senior (2017) and Allen et al (2014) have previously highlighted how the knowledge and skill of the facilitator is crucial to a positive experience of teaching and learning in IPE and Kaldheim et al (2021) have stated that the importance of the facilitator having pedagogical competence, being informative and giving constructive feedback. In this study Jo[1] identified a situation where a facilitator had made a comment in her feedback which Jo[1] felt was ill informed and incorrect and showed a lack of knowledge of another profession on the part of the facilitator (Jo[1]*; interview 2 p 86*). She felt that the facilitator had shown a lack of knowledge which undermined her confidence in the IPE process.

Similarly, Kelley and Aston (2011) have previously observed that variation in facilitator styles can complicate student learning. This was apparent from this study, particularly for Jo[1] and Meg[1], who following the 2012 curriculum and for whom the CP modules were assessed. Both commented on the importance of consistency and continuity of facilitation. Where there was a lack of consistency, students were confused as to what was expected of them in the assessment. Jo[1] expressed a concern that what one marker would be looking for would not be the same as what another was looking for (Jo[1]*; interview 2 p 92*), and Meg[1] proposed that having the same facilitator consistently would enable the facilitator to develop a better understanding of the student's learning needs and

styles and adapt their approach to facilitating accordingly (Meg[1]*; Interview 2 p 92*). Meg[1] admitted that she had not attended sessions as a result of having a different facilitator scheduled.

Whiting et al (2016) have previously reported that students learn about IPW by spending time observing and shadowing other. Osman (2017), Bahnsen et al (2013) and Roberts and Goodhand (2017) have all reported 'clinically relevant learning' as being an important factor in positive experiences of IPE. Derbyshire and Machin (2011) suggested IPE should be as practice focused as possible to improve its relevance and Kelley and Aston (2011) and Williamson et al (2011) have argued that IPE is most effective when experienced in clinical practice and promotes effective joint working between health and social care professionals. It was evident from this study that all four students associated IPE with clinical placement and spending time with health professionals in the workplace. They related this to experiences with professionals from other disciplines and their own professions, with Jo[1] referring to spending time with occupational therapists, physiotherapists, podiatrists, nurses and doctors, Meg[1] and Beth[2] referring to time spent with midwives and obstetricians and Amy[2] commenting on the value of working alongside doctors and other nurses. Both Jo[1] and Meg[1] specifically talked about how they felt that they had learnt about others roles from placement rather than classroom-based experiences (Meg[1] *and* Jo[1]*, Interview 2 p 71*).

Roberts and Goodhand (2017) and Kaldheim et al (2021) have reported positive views about simulation as an IPE activity and Meg[1] commented in both interviews on how she would prefer practical based IPE activities to those that are more theoretical (Meg[1]*; Interview 1 p 63, Interview 2 p 91*). Jo[1] also seemed to be of the opinion that IPE sessions that were theory driven negatively affected engagement of students (Jo[1]*; interview 2 p 91*). Engagement of students in IPE clearly emerged as an issue of concern in this study and may be a result of the design of the delivery. Osman (2017) found that students engaged well with experiences perceived to be 'realistic' or 'relevant' to their future practice but likewise they complained about 'generic teambuilding' activities and how this negatively affected their engagement. Meg[1] and Jo[1] in particularly noted the lack of engagement of students studying the 2012 curriculum in the CP IPE sessions with significant reductions in the numbers of students attending the sessions as the module progressed. Jo[1] suggested that "had the interest been there, people would have engaged" (Jo[1]*; Interview 2 p 92*).

Amy[2] and Beth[2] who followed the 2017 curriculum were less critical of the method of delivery of the IPE sessions affecting engagement and seemed more concerned about the lack of willingness of students to engage in IPE, and in particular to leave their own professional groups. Beth[2] expressed frustration with those students who were reluctant to leave their own professional group. She referred to an immaturity of some students by failing to take advantage of the limited opportunities

to mix with other students from other professional groups when she referred to students needing to act as 'grown ups' and 'make the most' of 'the one day in our academic year where we get to sit down with the paramedics, or the mental health nurses, or the nurses, or the ODPs.' (Beth[2]*; Interview 1 p 64*). Likewise, Amy[2] was of the opinion that IPE required engagement from the students in order for them to benefit when she said 'If you want to know about something and you do your bit and you take part' (Amy[2]*; Interview 1 p 63*).

The impact of the attitude of senior staff on IPE was also raised. Whiting et al (2016) discussed the role of mentors facilitating IPE opportunities in the clinical environment, and Wright et al (2012) highlighted the influence that IPE facilitators can have on the perception by students of their own and others' professions. Meg[1] was concerned that there appeared to be a lack of enthusiasm to engage in IPE by senior staff when she talked about "people who are very high up the chain are probably less likely to engage" (Meg[1]*; Interview 2 p 92*). Jo[1] also suggested that there was a lack of a willingness from senior staff to engage in IPE, when she commented "you're not going to get them to do it at that level, I don't think, although they could certainly use it..." (Jo[1]*; Interview 2 p 93*). Meg[1] was evidently concerned that as a result the positives which may come out of IPE were not materialising, and she talked about people attending training but continuing to practice in the same way – what she termed doing "that lip service thing" (Meg[1]*; Interview 2 p 93*). This resonates with observations by Leedham-Green et al (2019) who noted students reflecting on the discrepancy between what is taught and what is practised, noting that their teaching promoted respect, empathy and good communication, however in practice they experienced miscommunication, no communication and blaming between professions.

6.6 Hierarchy, Status and Power

Issues of hierarchy, status and power and IPE have been raised previously by others. Stephens and Ormandy (2018) reported students benefitting from interactions where there was 'flat hierarchy' within IPE groups and between facilitators and students. Clancy et al (2020) discussed the 'power' that lecturers have 'over students' impacting on students feeling less safe to share and discuss their experiences. Others have explored the influence of hierarchy and power between and within professions (Tran et al 2018, Telford and Senior 2017, O'Carroll et al 2016, Wright et al 2012 and Leedham-Green 2019). Tran et al 2018 reported students experiencing hierarchy among healthcare professionals, and that this hindered collaboration. Leedham-Green et al (2019) found that students experienced hierarchy within professions and tribalism between professions which was damaging to patient care and staff wellbeing. Telford and Senior (2017) suggested that there are power dynamics that exist between health professions and that 'power struggles between groups' may negatively

affect IPE, and Leedham-Green et al (2019) similarly reported 'adversarial encounters' between nursing and medical students during campus-based IPE. O'Carroll et al (2016) considered professional identity, professional culture and inter professional hierarchies and how these may influence attitudes to IPE and IPW. They suggested that perceptions of power may negatively impact on attitudes to IPE and IPW, and that doctors were likely to be less engaged in IPE and IPW in comparison to nurses and allied health professionals, with this being linked to a perception of their role as doctors as the main decision makers in the healthcare team. Leedham-Green et al (2019) reported students commenting on how tribalism between the professions extended into social relationships, with friendships tending to form within, but not between, professions. However, they also suggested that students showed insight into how informal social communication and personal friendship could counter the adverse impacts of hierarchy or tribalism.

For all participants in this study, hierarchy and status emerged as a strong issue from their experiences. All had experiences of hierarchy between health professionals. Beth[2] and Jo[1] were of the opinion that hierarchy was perhaps not common to all settings, and Beth[2] also suggested that at times hierarchy was not always a negative thing, linking it to positive aspects of decision making and limits of practice (Beth[2] *and* Jo[1] *interview 1 p 52*). In common with the findings of others, participants generally commented on the perceived position of doctors at the top of the hierarchy, and echoing the findings of Leedham-Green et al (2019) citing examples of lack of respect for juniors being shown by seniors, three of the participants described examples of where they had experienced themselves, or observed colleagues experiencing, negative interactions with senior staff, usually doctors. Meg[1] recounted observing an interaction between a consultant and a midwife where the consultant undermined the midwife and another occasion where she herself had been shouted at by an anaesthetist (Meg[1]*; Interview 1 p 54),* Jo[1] described a situation where a doctor presumed that he could interrupt an assessment that she was doing in order to speak to the patient (Jo[1]*; Interview 1 p 55*), and Beth[2] recounted an experience where a doctor had left her feeling intimidated and undermined during a handover (Beth[2]*; Interview 1 p 54*). Meg[1] clearly felt quite strongly about this when she commented "Consultants, they don't give a shit about you.." (Meg[1]*; Interview 1 p 53),* although both Beth[2] and Meg[1] conceded that an attitude such as this maybe individualised rather than associated with a particular profession or grade within a profession (Beth[2] *&* Meg[1]*; Interview 1 p 53*). Amy[2] considered expressions of hierarchy and superiority were not confined to one profession. She observed that other individuals may deem themselves to be superior to others because of their position in the organisation when reflecting on how the ward manager would never be seen interacting with some other professionals because, as Amy[2] suggested, that person was 'beneath her' (Amy[2]*; Interview 1 p 53*). Similarly others talked of hierarchy within professions with

Meg[1] talking about a hierarchy within the midwifery profession (Meg[1]*; Interview 1 p 55*), and Amy[2] suggesting that doctors and nurses have their own hierarchy amongst themselves (Amy[2]*; Interview 1 p 55*), however Beth[2] was of the opinion that status within a profession based on banding and seniority was different to a hierarchy (Beth[2]*; Interview 1 p 55*).

But the incidents experienced by the participants clearly had a strong emotional impact on them. Meg[1] referred to wanting "to burst into tears and run out of the room" (Meg[1]*; Interview 1 p 54*), and when hierarchy may have been seen to be challenged, Amy[2] said she felt "it was like a pack of lions and I was like the little cub in the middle" (Amy[2]*; Interview 1 p 56*). Similarly, Jo[1] reported feeling embarrassed and how she "was going red" (Jo[1]*, Interview 1 p 58*). Interestingly, with reference to this feeling of being embarrassed, Jo[1] seemed to be embarrassed by the fact that she was a student and was seen to be challenging the doctor (although in fact it was the patient's relative who challenged the doctor), in fact she said that "I was only in my place as a student and I was more than happy to get up and say, yeah, do what you got to do I'll come back" (Beth[2]*, Interview 1 p 58)* suggesting that the issue of hierarchy here may be more to do with the participant's status as students rather than a particular professional group, and that this was accepted by Beth[2]. Meg[1] who referred to the position of students in the hierarchy when she said "It is the way it's always been done, Students are just, just a nothing." (Meg[1]*; Interview 2 p 82*). Similarly Amy[2] outlined how she felt that the position of students within the hierarchy existed in practice referring to "there's consultants and then it's registrars, and you've got like your F1 doctors, you've got the SHOs then you've got matrons, and then you got ward nurses, and then you've got even clinical support workers. And then you have student nurses." (Amy[2]*; Interview 2 p 81*).

In line with the observations of Clancy et al (2020) regarding the 'power' that lecturers have 'over students', Amy[2] also referred to a hierarchy within the education setting, commenting on the 'blessed' privileged position held by lecturers "at the top and we're the students and we're at the bottom…" (Amy[2]*; Interview 1 p 55*). And resonating with the findings of Leedham-Green et al (2019) who reported 'adversarial encounters' between nursing and medical students during campus-based IPE and how O'Carroll et al (2016) considered how professional identity, professional culture and inter professional hierarchies may influence attitudes to IPE, Jo[1] commented on how she felt that during the classroom based IPE sessions she experienced, some groups of students placed themselves in a superior position to other groups of students. She referred to 'a lack of respect' in this regard (Jo[1]*; Interview 1 p 55*).

The issue of respect was raised as important when it came to hierarchy. Jo[1] said "there shouldn't be a hierarchy, there should be respect for one another's profession" (Jo[1]*; Interview 2 p 84).* It would

seem that for Jo[1] it was important for knowledge, skills and experience to be recognised between professions. She explained how she had observed this respect for her own profession shown by staff from other professional groups whilst on placement on the ward (Jo[1]*; Interview 2 p 84*). Amy[2] agreed with this sense of recognition of knowledge and skills between professions when she suggested that some professions did not fit within a traditional hierarchy – that there was a sense of the 'transcience' of the role affected their status in that they were present when their expertise was required and at that point they were considered to be very important, but since they were not 'present' when they were not required, they were not then considered to be important (Amy[2]*; Interview 2 p 83*). Beth[2] acknowledged that there was a need for a hierarchy to enable decision making, however she also reported that from her experience that she had observed a flatter command structure than a traditional hierarchy may suggest (Beth[2]*; Interview 2 p 83*). And for Beth[2] the concept of partnership and co-operation was in evidence from her experiences in placement and important to her. She used the quite illustrative analogy of an ant colony - "everybody has their own role and... It's like ants isn't it .. it works if everybody is working together." (Beth[2]*; Interview 2 p 83*).

Like the students that Leedham-Green et al (2019) reported expressing a desire to engage in positive change even after negative experiences, Beth[2] also stated that she thought that it was the responsibility of each individual, particularly those entering the profession, to ensure that concept of hierarchies which had been built up by convention and tradition be challenged in order to remove the negative preconceptions and attitudes that had perhaps previously prevailed (Beth[2]*; Interview 2 p 84*). In fact both Beth[2] and Amy[2] seemed to be of suggest that previous generations of professionals had established a hierarchy but that was now being challenged by those new to the professions as evidenced by the statements "health care was allowed to be a hierarchy… I think it takes a while to break down those hierarchies" (Beth[2]*; Interview 1 p 59*) and "…it's little things like hierarchy, it's changed because whereas I always thought, you know, if you're at the top, you're always right. Now, I know that... you know.. You don't." (Amy[2]*; Interview 1 p 59*). In agreement with Leedham-Green et al (2019), Tran et al (2018) and Wright et al (2012) Beth[2] certainly seemed to be of the opinion that IPE had a role to play in combating the negative aspects of hierarchies by suggesting there were "..other benefits of IPE, of building relationships and breaking down these hierarchies and creating better teamwork…" (Beth[2]*; Interview 2 p 94*)

6.7 Self Awareness

The literature refers to the effect that IPE has on self-awareness of participants. O'Carroll et al (2016) reported the literature suggested that qualified staff with experience of IPE in their pre-qualifying education had increased self-awareness of positioning in a team, compared to those

without prior IPE experience, and Kaldheim et al (2021) commented that learner self-confidence can be improved through IPE experiences. Hallin and Kiessling (2016) proposed that students developed an increased self-confidence and knowledge about themselves during an interprofessional training ward experience and that through IPE, students developed confidence in their choice of profession, faith in the competence of other professions and a comprehensive view of patient care.

Two participants in this study particularly emphasised the impact that participating in IPE had on their self-awareness. A significant element that emerged from both interviews with Amy[2] was how through the IPE sessions she engaged in, the interaction with people from other professional groups that she would not normally have interacted with led to a developing of her own self-awareness, particularly in terms of her own behaviours and how others may perceive her. In the first interview she reflected on a group activity that she participated on during an IPE day and she explained how she came to realise that she had dominated the group discussion – "like I was taking over" (Amy[2]*; Interview 1 p 50*) – without realising it. She said she had not intended to take over, rather she was being enthusiastic about getting her ideas across, but this enthusiasm had resulted in the others in the group not being able to discuss their ideas. It was only when one of the other students pointed out what she had done and how the others had felt that Amy[2] appreciated what she had done. This made her consider whether this was what she had been doing in other groups, but no-one had raised it with her, perhaps as a result of them being used to her behaving like this. It had taken a group she had not worked with before to highlight her behaviour. This seemed to be quite a profound learning experience for Amy[2]. She expressed how the realisation initially created some quite negative emotions in her – "…this is a weakness of mine. And I just made it like this bad thing and it brought me down a little bit" (Amy[2]*; Interview 1 p 51*), but having had conversations with her mentor, she managed to turn these into positives and has consciously made efforts to change her behaviour. Amy[2] referred to this increase in self-awareness which she felt she obtained as a release – describing it like a "bubble and it just burst" (Amy[2]*; Interview 1 p 65*).

Amy[2] also described how the IPE sessions had helped her understand the value of engagement and how she was transferring this into her engagement with her programme more generally. In her first interview she explained how she was now more confident to set her own learning agenda to ensure her needs were met – "I'm a student and I know what I need to learn and what I need to achieve" (Amy[2]*; Interview 1 p 65*).

Similar to Amy[2], in her second interview Beth[2] also discussed how the IPE session she had attended had enabled her to learn about herself and the impact of her behaviours and actions on others. During the course of the IPE session Beth[2] had got involved in a conversation with another midwifery

student during which they disagreed. There was a heated discussion where voices were raised, and some 'less than professional' language was used (Beth[2]*; Interview 2 p 77*). Beth[2] received feedback after the session from the lecturer that she thought her conduct had been inappropriate. This led Beth[2] to reflect on her behaviour, and how important it is to be aware of your conduct and how you may be perceived by others, particularly when interacting with individuals who you may not usually interact with. However, the concept of her being representative of her peers and profession also emerged as being important to Beth[2]. She commented that she felt that not only were other people forming opinions about her as an individual, but they were also forming opinions about midwifery students in general, and the midwifery profession as a whole as a result of their observations of her behaviour. She also proposed that this may have an impact on IPW – "I .. did quite a lot of reflecting about it and my behaviour and how that looks and power dynamics and leadership and, um, inter professional relationships and how it's so important that we have respect for each other and understanding each other." (Beth[2]*; Interview 2 p 78*). This was clearly a particular profound and powerful experience for Beth[2] as she said "… My biggest experience of IPE this year" (Beth[2]*; Interview 2 p 79*).

It is interesting to note that both Amy[2] and Beth[2] were following the 2017 curriculum, so they only participated in a limited number of core IPE days. The students following the 2012 curriculum (Meg[1] and Jo[1]) participated in a greater number of IPE days through engaging in the CP modules and so they may have been more familiar with engaging with other students from other professional groups so less likely to attach as much significance to the activities.

6.8 Race, Diversity and Inclusion

A final point for discussion which emerged from the interviews is that of race, diversity and inclusion. One student, Amy[2], commented at length and in some depth regarding this issue and IPE. Amy[2] commented that IPE offered the potential for students to learn from and about each other in the areas of race and cultural differences – "not just for me and the other BME students to be, to learn from each other, but for the, let's say the white students as well, to be aware of some of the things that... not that we would like to change or we would like, you know, for them to understand. But it's just for them to get a bit more understanding" (Amy[2]*; Interview 1 p 51*). In her second interview Amy[2] explained how she had started a BAME student support network because of her concerns around the attainment gap between BAME and non-BAME students. The initial aim was to address inequalities in attainment and to establish a forum whereby concerns around experiences and the attainment gap could be raised with the university and placements – Amy[2] described opportunities for her to raise concerns with Trust heads of equality and diversity and placement

facilitators on behalf of the students (Amy[2]*; Interview 2 p 79)*. But it was also a forum for Amy[2] to support the students in the groups. She explained how there was perhaps a cultural issue at the heart of these BAME students perceptions of their own achievements and she talked about how she had, for example, worked with the students to understand that an action plan should be seen as a positive – something to "help you and guide you to achieve what you need to achieve" (Amy[2]*; Interview 2 p 80*) – rather than as a negative – "you're not doing this right, it is wrong" (Amy[2]; Interview 2 *p 80*) – which Amy[2] referred to as having both cultural and age related origins – "most people doing like health care courses, they're quite mature students … and they've always grown up knowing that, you know, if you do something wrong, you get disciplined and you have to do this" (Amy[2]*; Interview 2 p 80*). However Amy[2] felt this fitted with her experiences of IPE because the groups she was working with were from many professional groups and the groups had subsequently emerged as an opportunity for the students within the groups to learn about and support each other interprofessionally and share experiences (Amy[2]*; Interview 2 p 80*). Amy[2] also felt that these interactions with other professional groups have changed how she herself perceives and interacts with individuals from other professional groups – "it's made me, like, challenge myself. When I'm working on placement … to actually go and speak to them and ask them questions … and learn from them" (Amy[2]*; Interview 2 p 80*).

Amy[2] also referred to how she felt race was an issue when it came to hierarchy within the workplace – "the white nurses are at the top. Then you have another race in the middle and then you have another race at the bottom" (Amy[2]*; Interview 1 p 57*), and Amy[2] referred to some of the experiences described by members of the support group she had formed relating to race and inequality; "awful, awful experiences, like other health professional things, stuff that's been said to them by staff, how they're treated and how like, discrimination in the workplace..." (Amy[2]*; Interview 2 p 79*). Although Amy[2] did not mention that she herself had experienced discrimination in such a way, it is clear that she was suggesting that this does occur. During her second interview, Amy[2] described how she had felt her race was an issue when she was on her India trip describing how she felt both patients and staff were treating her differently on the basis of her colour - "I'm not getting treated professionally how I expected to be treated. But then it's now then gone on to a personal level where, like, my race is an issue" and "And then you're not just the student. You know, you're the black student" (Amy[2]*; Interview 2 p 87*). However she seemed to offer the view that she found discrimination to be more apparent in India than in the UK – "you walk into a hospital and everyone's like 'Oh hi', and everything's fine because I've never faced that discrimination here." (Amy[2]*; Interview 2 p 87*).

The literature reviewed did not refer to race, equality or diversity with regard to IPE. There has been no evident discussion of the role that race might play in the experience of IPE by students. Of course

the issue of race, equality and diversity in HE in the UK has been explored and investigated by many recently, particularly around concepts such as decolonising the curriculum and BAME attainment gap (for example Memon and Jivraj (2020), UUK (2019), Brathwaite (2018), Claridge et al (2018), Francois (2020), Godbold and Brathwaite (2021), and it is clear that this is a major topic of concern and interest generally.

A number of authors have explored the experiences of BAME students in Higher Education in the UK, and it is interesting to note how these findings from these studies resonate with the experiences described by Amy[2] and the other participants when describing their experiences with a focus on IPE. Claridge et al (2018) studied the experiences of medical and biomedical science students to explore factors contributing to the attainment gap. They found that many students reported that whilst they felt that the university is very diverse, they felt integration was difficult due to apparent ethnic divisions, and this was seen in both social and academic settings. In this study Amy[2] reported how she had facilitated a group for BAME students to come together to support each other in an attempt to address the issue around the cultural issue affecting the BAME students perceptions of their own achievements. The suggestion here is that only BAME students would understand these issues and so support would be best achieved from students experiencing the same feelings. Claridge et al (2018) reported students self-segregating by ethnicity in lecture settings with white students and black students sitting apart and one student commenting that people rarely made friends outside of their cultural groups and that. It is interesting to draw parallels here with the observations of participants in this study around how students from each profession tended to sit together and there was no mixing, such as Beth[2], Amy[2] and Jo[1] (*Interview 1* page 59) . In this study Amy[2] offered the opinion that perhaps IPE provided the potential for students to learn from and about each other with regard to race and cultural differences as well as professional differences. They (Claridge et al 2018) also commented that some students felt that they were treated differently by other students because of their ethnicity and reporting black students were more likely to feel isolated and uncomfortable in their HE environment than other students, and that they are likely to be members of smaller social networks. Jones at al (2019) have reported that 'belonging' is a key issue for BAME students – proposing that this is a subjective feeling of 'relatedness and connectedness' to the HEI and cited Strayorn (2018) as suggesting that acceptance by peers, in the classroom and at the university can have an effect on achievement. Interestingly, in investigations of IPE, authors have reported similar feelings of isolation and intimidation expressed by students when they were the only student from their profession in an interprofessional group (Telford and Senior 2017, Courtenay et al, 2103, Allen et al 2014). Some parallels can therefore be drawn between feelings of isolation

experienced by students from one profession when in a group made up of other professions with those of BAME students amongst a predominantly white student group.

Claridge has also (2018) also referred to stereotyping and reported black students experiencing or witnessing stereotyping and prejudice by other students, academic staff and clinical staff whilst on placements. In this study Amy[2] described where she or other BAME students had experienced prejudice and discrimination. Godbold and Braithwaite (2018) proposed that BAME students on clinical placement often experience ethnic and racial prejudices). And, again with an interesting parallel regarding stereotyping and prejudice on a professional basis, or with regard to their position as students, students in this study described experiencing prejudice in the way they were treated ("Consultants they don't give a shit about you .. they don't.. they look at you in the office and don't, don't speak to you…. Meg[1]; *Interview 1* p.53). They suggested, however, that IPE had a function in addressing issues of stereotyping, prejudice and breaking down barriers between professions and that the concept of just having contact with individuals from other professions also seemed to be important.

Although the literature reviewed did not refer to race, equality or diversity with regard to IPE, and there appears to have been no evident discussion of the role that race might play in the experience of IPE by students, the fact that one student in this study highlighted race, equality and diversity when discussing her experiences of IPE, is of note. It is also important to consider the implications of the issues of discrimination, prejudice and stereotyping which BAME students clearly do experience and have been well documented, within the context of IPE. Both within this study and in the wider literature, students clearly regard the issues of discrimination, prejudice and stereotyping as being a key issue inter, and intra professionally. Students have reported being treated unfairly and discriminated against on the basis of either their profession or their position as students by either senior staff and/or by colleages. So it can be assumed that if non-BAME students report such experiences, BAME students may experience such treatment, but potentially to a greater extent than their white counterparts since the issue of race will compound the issue.

It is therefore important that this issue be investigated more thoroughly and the role that IPE may play in addressing the issue. Godbold and Braithwaite (2018) refer to the combination of the racially hostile environments of Higher Education, Practice Placements and the NHS presenting a daunting prospect for BAME students, and Braithwaite (2018) states that equitable care delivery to all patients cannot be expected without identifying the racially based unconscious bias and stereotyping that exists in our universities.

6.9 Themes emerging relating to Theoretical Framework of Contact Theory

6.9.1 Learning with, from and about others

Findings from this study support the general view that the concept of having contact with students and professionals from different groups positively affects how members of other professional groups may be perceived and can improve working relationships, both in the present but also possibly in the future. Meg[1] referred to an informal conversation with a doctor who she was working with whilst on placement where she said "she's learnt a bit about me and I learnt a bit about her, you know" (Meg[1]*; Interview 1 p 48*) and "Yeah, these are midwives. Yeah, these are the doctors but actually they're actually people too" (Meg[1]*; Interview 1 p 49*). Similarly, Beth[2] observed of working with other professionals, "it's nice to know, kind of, their backgrounds and maybe where they've come from and what they deal with and to have conversations" (Beth[2]*; Interview 1 p 49*).

These observations resonate with the fundamental proposition of Allport (1954) that prejudice and hostility between groups can be reduced by bringing members of the different groups together. It is particularly noticeable that Meg[1] stated that contact 'humanised' other people (Meg[1]*; Interview 1 p 49*) and Beth[2] observed the importance of having 'a conversation and to appreciate the journey that everybody else is on ' (Beth[2]*; Interview 1 p 45*) which suggests that contact allows individuals to develop an understanding of others, perhaps through a focus on both similarities and differences between members of the groups – one of the requirements deemed necessary for attitude change to occur by Hewstone and Brown (1986).

When considering learning from, and about others, results were mixed. Whilst some felt that their experience of IPE had allowed them to gain an insight into the role of others and it was acknowledged that this was one of the fundamental purposes of IPE, some felt that this had only been achieved to a limited extent. This appeared to be as a result of facilitation, whether that be through being asked to work in the classroom IPE sessions with people who were from professions they did not usually work with, or through not being given enough opportunity to share information with the group and expecting students to be pro-active and seek out opportunities for themselves. Facilitation is the responsibility of the institution and its staff, and so may refer to another of the key requirements deemed necessary under Contact Theory (Allport 1954) - support by social and institutional authorities. Although it may be argued that this support from the institution was present at a 'strategic' level by the virtue of the fact that the sessions were scheduled and resourced, support must also be available at a more 'operational' level with staff ensuring that groups are mixed appropriately and the sessions themselves allow the opportunity for contact to be encouraged.

It is interesting that all four students associated IPE with clinical placement and spending time with health professionals in the workplace. Others (Williamson et al, 2011) have argued that IPE is most effective when experienced in clinical practice. Jo[1] and Meg[1] particularly talked about how they had learnt about others' roles, from placement rather than classroom-based experiences. The fundamental aspect of placement is that students, and the practitioners they are working with are focussed on clinical tasks. Requirements according to Allport's (1954) Contact Theory are the concept of 'common goals' and 'intergroup cooperation'. It is likely that when students are working together with students or other practitioners from other profession, they will be sharing a goal – often relating to a specific client or patient. Likewise, it is anticipated and hoped that this working towards a common goal will have a successful outcome – one of the additional factors identified by Hewstone and Brown (1986) to be crucial. The words used by Beth[2] when she said that an increased awareness of others' roles could lead to a "less of a them and us. It would be more just us" (Beth[2]*; Interview 1 p 46)* certainly seem to resonate with these concepts.

6.9.2 Communication and Teamwork

The key requirement of 'common goals' highlighted by Allport (1954) seems highly relevant to the findings as communication and teamwork emerged as a theme. Beth[2] recognised that IPE had helped to improve her own communication skills and abilities to work in a team and stated that she considered one of the benefits of IPE to be building relationships and creating better teamwork. Amy[2] referred to the importance of IPE promoting the concept of breaking down barriers between individuals and encouraging the building of teams, a team ethic and teamwork. But, as it emerged, it is the result of this teamwork which is important – and that is the outcome of a benefit to the service user. Jo[1] talked about 'different setting, different pathways or different professions, but all with the same goal' (Jo[1]*; Interview 1 p 47*). Beth[2] also suggested that having personal connections amongst healthcare professionals ultimately benefitted the service users, and that IPE was a way to make these connections (Beth[2]*; Interview 1 p 44).* Jo[1] recognised that IPE could play a role in understanding the value of shared goals and outcomes by when she said 'one thing I have learned is that regardless of anybody's attitude or opinion about another pathway, we all have the same goal, which is ultimately to help or improve somebody's life' (Jo[1]*; Interview 1 p 42*). Not only do these comments resonate with Allport's (1954) requirement of common goals, but also the successful outcome identified by Hewstone and Brown (1986).

6.9.3 Facilitation

As stated previously, facilitation may be considered to be the responsibility of the institution and its staff, and so may refer to another of the key requirements deemed necessary by Allport (1954) for

Contact Theory to apply - support by social and institutional authorities. In addition to the facilitation of being able to mix with students from other professions as already discussed, other aspects of facilitation that emerged from this study can be considered using Contact Theory. The organisation and scheduling of the sessions was raised by all the participants in the study. Those following the 2017 curriculum, Amy[2] and Beth[2], said they felt that there were not enough sessions dedicated to IPE in the timetable. Likewise, those on the 2012 curriculum, Jo[1] and Meg[1] reported that having the sessions spread so far apart throughout the year was an issue. In fact Jo[1] said she felt that IPE as a concept lost credibility and suggested that 'we're only doing it three times a year, it can't be that important?' (Jo[1]*; Interview 1 p 67*). By saying there should be more sessions, or that the sessions are too far apart it may be argued that the students are suggesting that support by the institution was not perhaps as evident as it should be, since it is the institution, through teaching staff and programme validation procedures that decides the curriculum and the scheduling of learning.

The attitude shown to the subject and IPE in general by the facilitators emerged to be of significant importance to the participants in this study. Meg[1] in particular focussed on the attitude of the facilitator and the way the facilitator spoke to the group. Again, it may not be considered too unreasonable to suggest that a positive attitude by facilitators suggests support, and a negative attitude suggests a lack of support. Students may regard the facilitators to be 'the institution', and so their support may be deemed to be reflective of the support of the institution.

Engagement is clearly key to the success of IPE. Meg[1] and Jo[1] noted the lack of engagement of students studying the 2012 curriculum in the CP IPE sessions, commenting on significant decreases in student attendance as the module progressed. Both suggested that they felt that lack of engagement was linked to lack of interest and that this may have been because of the design and/or delivery. Design and delivery may again be considered to be the responsibility of the academic staff (the institution) and so support from the institution would seem to be a valid issue here. Similarly, Amy[2] and Beth[2] who followed the 2017 curriculum were concerned about the lack of willingness of students to engage in IPE, and in particular to leave their own professional groups. One of the additional factors identified as crucial by Hewstone and Brown (1986) is that participants in the contact need to have positive expectations. Whilst the institution plays an important role in generating expectations, Amy[2] and Beth[2] did seem to suggest that this also needs to come from the students themselves, and from their experiences this was not always present.

Certainly in relation to facilitation and institutional support, Meg[1]'s comment about "people who are very high up the chain are probably less likely to engage" (Meg[1]*; Interview 2 p 87*) applies. Likewise, Meg's[1] comments regarding 'lip service' (Meg[1]*; Interview 2 p 93*) when she referred to training being

made available and people attending, but practice not changing are relevant to the concept of institutional support.

6.9.4 Hierarchy, Status and Power

Mohaupt et al (2012) proposed that contact theory is a useful theoretical framework for IPE as it addresses the concepts of stereotypes, social groups and hierarchy. The issues of hierarchy, status and power emerged strongly from this study. The concept of hierarchy in itself suggests a lack of equality. Allport (1954) deemed equal status to be a condition for contact to affect attitudinal change. All the participants in this study had experiences of hierarchy between health professionals, and seemed to generally report a lack of 'equality'. Three of the participants described examples of where they themselves had experienced, or observed colleagues experiencing, negative interactions with senior staff. There was a feeling that expressions of hierarchy and superiority were not confined to one profession and that individuals may deem themselves to be superior to others as a result of their position in the organisation. Meg[1] referred to her position as a student as being 'a nothing' and said how it made her feel 'feel really cross that that's kind of accepted' (Meg[1]*; Interview 2 p 82*).

The issue of respect was raised as important when it came to hierarchy. Jo[1] said 'there shouldn't be a hierarchy, there should be respect for one another's profession' (Jo[1]*; Interview 2 p 84).* There seemed to be a recognition that where expertise was recognised, each profession had equal value. And related to this was the recognition of Allport's (1954) other conditions of intergroup cooperation and common goals. For Beth[2] the concept of partnership and co-operation was in evidence from her experiences in placement and she used the quite strong illustrative analogy of an ant colony - 'everybody has their own role and... It's like ants isn't it .. it works if everybody is working together' (Beth[2]*; Interview 2 p 83*).

6.9.5 Self Awareness

One of the additional factors to have been identified as crucial to Contact Theory by Hewstone and Brown (1986) is that there needs to be a focus on both similarities and differences between members of the groups. Two participants in this study particularly emphasised the impact that participating in IPE had on their self-awareness, and this may be as a result of realising, identifying and understanding similarities and differences. Amy[2] talked about how the IPE sessions had led to a developing of her own self-awareness, particularly in terms of her own behaviours and how others may perceive her. Similarly, Beth[2] discussed how the IPE session she had attended had enabled her to learn about herself and the impact of her behaviours and actions on others. She described how

she came to realise how there may be differences between what may be accepted and expected by one professional group and another.

6.9.6 Race, Diversity and Inclusion

One student commented at length and in some depth regarding the issue of Race, Diversity and

Inclusion and IPE. There has been no evident discussion of the role that race might play in the experience of IPE by students , and although an in-depth discussion of issues surrounding race, equality and diversity in HE in the UK is beyond the boundaries of this study, the fact that this has been highlighted discussing experiences of IPE is of interest and important. Of course the origins of Allport's (1954) Contact Theory lie in the investigation of race relations and certainly one of the conditions of 'equal status' is particularly relevant here. In this study Amy[2] talked about race being an issue when it came to hierarchy within the work-place, and referred to some of the experiences described by members of the support group she had formed relating to race and inequality. With regard to IPE she commented that IPE offered the potential for students to learn from and about each other in the areas of race and cultural differences as well as professional differences.

6.10 Reflexivity

6.10.1 Introduction

The aim of this section is to examine the effect that I myself have had on this research. This has helped me check whether my own biases (conscious or unconscious), assumptions or prejudices have affected the research in any way. Reflexivity during the research process enables the recognition of the relationship which is established between the researcher and the participants. Reflexivity is an important methodological tool in qualitative inquiry and it entails critical self-reflection about the impact that researchers have on each stage of the research journey (Mann 2016). It is the recognition that personal factors that can influence or bias research. I was helped to practice effective reflexivity during meetings and discussions with my supervisor. During this study I have tried to use reflexivity as a continual process of self-reflection on my preconceptions, biases or assumptions that I may have had due to personal or professional experience which could affect the research.

6.10.2 Selecting the study

I was initially drawn towards this area of research during the taught component of my EdD course. I had always thought of myself as being in the 'quantitative camp' of the 'qualitative – quantitative'

research divide. I enjoyed science at school and it was the scientific aspect of diagnostic imaging that was a strong driver in me choosing radiography as a career in the first place. Although I acknowledged the 'caring aspect' of the role of the radiographer, I always felt I was a 'scientist' by nature. I have previously engaged in research as part of a BSc, MSc and MPA programmes, and each time I have chosen a quantitative approach. I thought the best way to the truth was through 'measuring things' and 'proving' that something does or should happen. In my career as a radiography educator I have usually been involved in the delivery of the radiographic science or technique modules. However as I began to take on the taught component of the EdD module, I was asked to develop a module in the radiography BSc that focussed on how patients experience diagnostic imaging investigations. Students are asked to consider the diagnostic imaging procedure, not as a technical process, but rather as in interaction between patients and the radiographer. They are asked to consider how it 'feels' to be a patient and to understand that this can only be explained by the patient themselves, and so listening to the 'patient voice is important. As a result of this I began to consider my own practice as an educator, and thinking about how my students experience their education. The actual experience is how the student perceives it and can only be explained by the student. This is the importance of the student voice. At the time the delivery of IPE within the faculty was undergoing a change. This study gave me an opportunity to investigate the experience of students engaging in IPE both in the outgoing and incoming curriculum from their perspective – to hear their voice. It would enable me to understand the situation better because I would be able to hear directly from the students rather than relying on module evaluations and anecdotal evidence.

6.10.3 Methodology

IPA was first brought to my attention by one of my tutors on the EdD course. What interested me was the possibility of developing a qualitative design to 'listen' to the student voice, but being able to thoroughly analyse the data in an organised and structured way. As a diagnostic radiographer, demonstrating organisation, working to protocol and attention to detail are fundamental and necessary qualities for the radiography profession. IPA provides an organised and structured way to thoroughly analyse the data but also requires interpretation and imagination to create meaning from the data. Thus I felt excited by the process enabling me to satisfy myself on both fronts.

I initially considered a Grounded Theory approach. Grounded theory aims to develop a theory of social processes, studied in the environments in which they take place (Starks and Brown 2007). In grounded theory the researcher acts as a witness and presents an account of the social reality. There is a deliberate attempt to ensure their own preconceptions are not introduced into the research (Carpenter 2009). Grounded theory and IPA are similar in that they are both approaches which are

inductive – information is gathered and conclusions are drawn from what is observed. However, it may ultimately be suggested that grounded theory attempts to develop a theoretical claim, whereas IPA aims to identify potentially broader issues from the analysis of individual accounts. There is also the issue that in Grounded Theory research the collection of data often continues until saturation is reached. I was working to a timescale and needed to plan accordingly to aim to complete the research within a defined period. I also needed to fit the research into my family and work commitments. Organisation and time management was required and an open ended arrangement would have been too challenging. I needed to plan ahead with data collection and a longitudinal study was the optimal way to investigate the student experience. From when I was first introduced to IPA it felt right and further reading, exploration and the experience of using this method in this study has consolidated this feeling.

6.10.4 Participants

When a lecturer interacts with students there is always an element of potential hierarchy and power dynamics which cannot be ignored. Clancy et al (2020) discussed how in their study, students commented on how their status as a student in the presence of staff made them feel vulnerable as a result of the 'power that lecturers have', and in this study Amy[2] referred to the privileged position held by lecturers and referred to hierarchy when she said "they are like in a blessed privilege, they're at the top and we're the students and we're at the bottom" (Amy[2]; *Interview 1* p 55). It is therefore important to address and minimise any power imbalance, avoid any coercion and ensure that participation is truly voluntary and informed.

I am closely involved in the BSc Diagnostic Radiography programme, and so students enrolled on that programme were not invited to participate in this study. Participants were recruited by a notice being placed on the cohort Blackboards asking for volunteers to participate in the study. In the call for volunteers I did not identify myself as a lecturer or as Director of IPE. Students who expressed an interest in the study were contacted by me with further information, including the participant information sheet. Again I did not identify myself as a lecturer or as Director of IPE. From those students who volunteered to participate, two were randomly selected from each cohort. I was not directly involved in the delivery of any IPE sessions to the participants in this study. Participants were recruited from programmes that I had no relationship with, other than the IPE elements. None of the participants were known to me personally, and to my knowledge none of the participants knew who I was before they agreed to participate.

6.10.5 Data.

As previously highlighted when a lecturer interacts with students there is always an element of potential hierarchy and power dynamics which cannot be ignored. So it is impossible to ignore that my position as a lecturer had some impact on how the participants felt, and perhaps how they responded during my interview with them. Efforts were made to minimise this impact. Interviews were conducted using a semi-structured approach with a predefined schedule in an attempt to remove the possibility of my views or opinions influencing those of the participants. Interviews were conducted face to face. I did initially consider conducting interviews by telephone. A criticism of my choice may be that face to face interviews might compound the power imbalance and that students may feel uncomfortable being in a one-to-one situation. However by conducting the interview face to face I felt that the environment could be more closely controlled in terms of positioning of seating etc. It could also be ensured that the participants were focussed and not distracted. There was also the issue of confidentiality and ensuring that privacy could be maintained which would enable the participants to be more open and honest than they might if others were listening in.

I engaged in a reflexive process by reflecting before, during, and after each interview which enabled effective learning. Interviewing was a skill that I did not possess at the start of my research and looking back at the transcriptions I can identify potentially leading questions posed in my early interviews where my influence on the research process was evident. This bias was addressed in later interviews and so I believe that I did what I could to reduce my influence on the data collected.

Before the second interviews I would reflect on what I already knew about the participant from the first interview. The semi-structured style of interviewing ensured that I had a prompt with the main themes to be explored, but it was important to ensure that the participant felt that they were leading the conversation and that they dictated the direction the interview took. I developed a style of interviewing which allowed the participant to talk about whatever they thought was important and allowed them to describe the situations they experienced which put them at the centre of the research.

During the interviews I felt it was important to be responsive to the direction that an interview was taking. Sometimes this was more problematic than others. I undertook a couple of interviews when I was very busy with other work. This made it difficult to really focus and concentrate on what the participant was saying. The use of an interview schedule was invaluable at these times but did mean that the researcher influence could have possibly been more prominent than on occasions when I was more responsive to the participant.

6.10.6 Theoretical framework.

As part of this research I was asked to explain my theoretical framework. I admit to some confusion over this question. A theoretical framework has been described to me as the structure that can hold or support a theory of a research study. This description has helped greatly throughout the development of themes and writing up my research. I have explored different theories and concepts during the period of the study but my main framework was decided upon relatively easily. The fundamental purpose of interprofessional education is bringing students from different professions together, and this led me to consider the importance of contact. I was introduced to Contact Theory during the taught part of my EdD and it seemed to basically fit – the idea that contact with individuals from another group can change the perception of an individual from another group of that group as a whole seemed to be at the centre of what I was trying to explore

6.10.7 Data Analysis

IPA by design aims to reduce the influence of the researcher (Smith et al, 2012). The use of left and right hand columns either side of the transcript to annotate comments and emergent themes helped to ensure that findings were grounded in the data. This process of first reviewing the transcript and then pausing for an opportunity to reflect helped to ensure that the data was being reviewed with fresh eyes for the analysis and helped to reduce personal opinion or subjectivity (Carpenter 2009). Likewise I made notes of any thoughts or observations I had whilst reading the transcripts which helped to identify any premature interpretation. It was important to suspend judgement and focus on what was actually presented in the transcript and this involved an element of bracketing and allowed new themes to emerge as well as themes which had emerged from the analysis of the previous transcript(s). Even though I did not know the students, I did find this process quite challenging and I did on occasion find myself making judgements on what the participants had said. To avoid this I tried to avoid analysing the transcripts for long period of times and found it better to break up the task into small chunks of time.

I analysed the data and identified the emergent themes ‘manually’. I did consider using NVivo to help code and thematically analyse the transcripts, however I ultimately chose not to do so. I felt a manual process would be more efficient and robust and I would have more confidence in the process as I was directly involved, rather than relying on an algorithm. It also helped that I only had a small sample to contend with – a large number or participants may have directed me to an alternative strategy.

Another factor which may have influenced my data analysis was the time between interviews and analysis. The interviews concluded just before the start of the CoVid Pandemic – the final interview took place on March 13th 2020 and the UK went into the first lockdown on 23rd March 2020. As a result of work pressures which were significant for all lecturers involved in healthcare courses – the pressures of trying to ensure students were able to progress, dealing with placement issues cannot be underestimated – I had to put my research on hold for almost a year. This had a two-fold impact. During this time period I was able to think about my research and spend some time reflecting on the interviews, which I think resulted in a more 'considered' analysis. However when it subsequently came to analysing the data, although I had the transcripts of the interviews, I am conscious that my memory of what had been said by the participants may have faded and so interpretation may have 'drifted' and been changed in a way which would not have occurred if the analysis had taken place in a more timely manner.

6.11 Summary

This chapter provides an overall analysis of the outcomes of both sets of interviews and a discussion of the findings in a broader context relating to the published literature. Having the opportunity to mix with students from other professions has been raised as an important aspect of IPE in the literature. Findings from this study would concur with this general view that the concept of having contact with students and professionals from different groups positively affects how members of other professional groups may be perceived and can improve working relationships, both in the present but also possibly in the future. Learning from, and about others has also been identified as an important aspect of IPE, however participants in this study expressed mixed feelings around this issue, with some talking about how their experience of IPE had allowed an insight into the role of others, whereas others were of the opinion that their IPE experiences had only enabled an understanding of the roles of others to a limited extent. In agreement with the literature there was a view that IPE helped take students out of their professional 'silos' and understand the challenges others have to face and overcome, and realise where these are similar to their own. Likewise, the participants felt that IPE provided an opportunity to enable individuals to inform others about their own roles as previous studies have identified.

Previous studies have highlighted the effect of IPE on improving communication and teamwork, and participants in this study recognised that IPE had helped to improve their own communication skills and abilities to work in a team. They also recognised as others have reported that effective communication and collaborative working contributes to better patient care and so IPE can benefit the service user.

One of the most significant influences of their experiences of IPE cited by the participants in this study was facilitation and this concurs with findings of previous studies. The benefit of working with people from other disciplines and that this contact is beneficial to preparation for clinical practice was particularly highlighted. Other factors such as scheduling and programme structure were discussed. Of significant importance to the participants in this study was the role of the facilitator, and in particular the attitude shown to the subject and IPE in general by the facilitators which resonated with the findings of others.

Issues of hierarchy, status and power and IPE have been raised previously by others and for all of the participants in this study, hierarchy and status emerged as a strong issue from their experiences. All had experienced hierarchy between health professionals and these experiences clearly had a strong emotional impact on the participants. The issue of respect was raised as important by the participants when it came to hierarchy; respect for each other and the expertise that others bring with them to a situation.

The literature contains some reference to the effect that IPE has on self awareness of participants and two participants in this study particularly emphasised the impact that participating in IPE had on their self awareness. One student also commented at length and in some depth on the issue of race, diversity and inclusion and IPE. However, the literature reviewed did not refer to race, equality or diversity with regard to IPE. There has been no evident discussion of the role that race might play in the experience of IPE by students, although the issue of race, equality and diversity in HE in the UK has been explored and investigated by many.

The chapter discussed how the themes that emerged related to the Theoretical Framework: Contact Theory and particularly explored how the factors identified to have been crucial to Contact Theory could be seen to present. Finally, there was an acknowledgement of how reflexivity had played a role in the conduct of the study by the researcher.

7.0 Chapter 7. Conclusion, Limitations and Recommendations

7.1 Conclusion

Using IPA this research investigated how pre-registration healthcare students experience IPE. It is generally recognised that IPE is important in enabling healthcare professionals, both pre and post qualifying to develop the skills to engage in effective collaborative practice which improves service and patient outcomes. The research involved four pre-registration healthcare students at CCCU in two different year groups who have experienced IPE delivered in different ways. Two participants were midwifery students, one participant was an occupational therapy student and one was an adult nursing student. The fundamental research question was 'What are the experiences and perceptions of pre-registration healthcare students of interprofessional education'.

The findings of the research will be of interest to both academic and clinical staff. Due to the idiographic nature of all IPA studies, this study offered an insight into the local context and these specific programmes, and is therefore principally of value at this level, however these insights are valuable in the broader context as local findings can enable some broader generalisations. Findings can be used to inform the development of IPE programmes and activities, as they highlight some of the issues associated with IPE that result in students having a positive, or conversely negative experience of IPE. Conclusions from the study will be identified in turn.

7.1.1 Contact

Contact with students and professionals from different groups positively affects how members of other professional groups may be perceived and can improve working relationships, both in the present but also possibly in the future. Contact allows a realisation and understanding that other students and health professionals face challenges, both different and similar, and suggest an element of common ground that can allow individuals from different professions to compare, contrast and somehow see something of themselves in each other.

7.1.2 Learning from and about others

Learning from and about others is an important aspect of IPE. Participants in this study highlighted that they benefit more in terms of learning from and about others when those students they engage with in IPE activities are from professions they are likely to interact with in the workplace. This makes the learning relevant and avoids the perception of 'box ticking' in terms of being seen to 'do' IPE.

7.1.3 Roles

IPE provides an opportunity to enable individuals to inform others about their own roles, and in doing so, individuals learn more about their chosen profession and their own roles. Pride in an individual's own profession can also be increased as a consequence of explaining their professional role and responsibilities

7.1.4 Facilitation

A unique element of this study was that participants were from two groups who experienced IPE in two different ways. this enabled some comparisons to be made between the experiences of the two groups. Two students in this study experienced IPE as part of a formal module where delivery was in two week blocks and two day-long seminars spread throughout the year. Those students felt that this resulted in the programme being disjointed and the 'flow' being interrupted. One student suggested that the credibility of IPE was reduced as a result of the scheduling by commenting "only doing it three times a year, it can't be that important?" Conversely two students experienced IPE through one formal 'core' event per year. These students wanted more with one suggesting it should be a module in it's own right. It seems therefore that there is a balance to be reached somewhere between the two approaches adopted in order to address the concerns expressed by the students with regard to delivery and scheduling.

The study also exposed that the role of the facilitator is a critical factor in IPE. It was clear that students are affected by the attitude of facilitators – where a facilitator is enthusiastic about IPE, students are more correspondingly more motivated to engage with the subject matter. Likewise, how the facilitators engage with the students is important.

New knowledge that emerged from this study was the impact of how facilitators communicate with students. One student was profoundly affected by the way a facilitator spoke to her in a way which she felt was quite dismissive and demotivating. This was a major contribution to the overall negative experience of IPE for her. She repeatedly commented on the 'poor choice' of words by the facilitator and underpins the importance of positive communication with students.

Similarly, consistency and continuity of facilitation emerged from this study as a factor which affects the experience of IPE, particularly where there is an assessed component. Those students in this study where IPE was assessed were confused as to what was expected of them in the assessment where there was a lack of consistency in facilitation – they felt they needed reassurance that the facilitator taking them for classes would be the person marking the assessment. Having the same

facilitator consistently also enables the facilitator to develop a better understanding of the student's learning needs and styles and adapt their approach to facilitating accordingly.

7.1.5 Setting

The participants in this study considered IPE to be something that happens in a variety of settings such as classroom based and on placement and they did not seem to differentiate IPE as something that happened in a particular setting, or something that was formal and organised or informal and opportunist. Working alongside other students, qualified staff from the same professional group as them or others, or classroom-based activities were all seen to be considered IPE. One student in this study identified her experiences during an elective placement in India as being IPE because she interacted with healthcare professionals and students (both health and non-health) from beyond her own professional group, as well as from different countries.

7.1.6. Hierarchy

A significant finding from this study was that all participants reported experiencing negative interactions where hierarchy was a factor, echoing experiences reported in previous studies. Hierarchy also has a negative impact on teamwork and patient outcomes. It was generally perceived by participants that IPE could reduce the impact of hierarchy and positively develop a teamwork ethos within the healthcare professions.

7.1.7 Self Awareness

New knowledge that emerged from this study from this study was the extent to which IPE activities can impact on student's self-awareness. Two students recounted specifically how IPE experiences had provided profound learning opportunities when it came to increased self-awareness. Both reflected on how the contextual setting of IPE – bringing them into contact with students from beyond their own professional group – had highlighted behaviours that they felt they would not have been made aware of if they had only remained in their own professional group. For both of them, although this focus on what they referred to as 'inappropriate' or 'weaknesses' initially resulted in negative thoughts, the experience resulted in them being able to reflect on their actions and consider the impact on others, and ultimately on them resolving to change their behaviours in a positive way. One referred to this as being "My biggest experience of IPE this year".

7.1.8 Race and Diversity

Although an unintended outcome, new knowledge emerging from the experiences of one student in this study appears to be the impact that race and diversity may have on the experience of IPE, and

the role that IPE may play in addressing race and diversity issues. The student commented that IPE may help students understand the experiences of students from other cultural, racial or ethnic backgrounds. She also referred to a BAME student support network group that she had set up to support BAME students. Initially the aim of the group had been to address inequalities in attainment and to establish a forum whereby concerns around experiences and the attainment gap could be raised with the university and placements. However, the group had subsequently emerged as an opportunity for the students to support each other interprofessionally and share experiences, and an opportunity to learn about each other and each other's roles, and how they perceive their own profession is considered by others. The student also referred to how she felt race was an issue when it came to hierarchy within the workplace both from her own experiences and from those of others. However, when she related her experiences in India to those in the UK she seemed to change her perception of discrimination. The literature reviewed to inform the development and direction of this study did not refer to race, equality or diversity and IPE directly. However there has been a great deal of attention in recent years paid to the issue of race, equality and diversity in HE in the UK, and indeed with regard to the experiences of BAME students on health courses. There has been no evident discussion of the role that race might play in the experience of IPE by students and so there is no discussion of this issue in previously published work. However it is well established that BAME students clearly do experience issues of discrimination, prejudice and stereotyping which and these have been well documented. Likewise Students have reported being treated unfairly and discriminated on the basis of either their profession or their position as students by either senior staff and/or by colleagues, both in this and in previous studies. So it can be assumed that if non-BAME students report such experiences, BAME students may also experience such treatment, but potentially to a greater extent than their white counterparts since the issue of race will compound the issue. It is therefore important that this issue be investigated more thoroughly and the role that IPE may play in addressing the issue

7.2 Limitations of this Research

Only papers published in professional, peer reviewed journals were included in the literature review and grey literature was excluded. This was to ensure the quality and 'provenance' of the literature reviewed. This decision was made on the basis that not all grey literature material is subject to a rigorous pre publication review process and also with regard to longevity – grey literature may be available for a short period only and may not be formally archived. However it should be acknowledged that this may have resulted in the possible omission of the consideration of some potentially relevant research.

This was a sample of four female students from a single institution. The students were two midwifery students, one OT student and one adult nursing student and so not all of the professional programmes were therefore represented. Small samples mean that results may not be generalisable beyond the sample. However, the nature of IPA is not to make any claims regarding generalisability, rather than the interest being specific to the participants themselves and their experiences. However, the study of individuals may permit some transferability to the wider population, since if one person feels about something in a particular way, it is likely that others may also.

Although the researcher was not directly involved with any of the specific programmes of study that the students were enrolled on, I was the Director of IPE and had been involved in some of the organisation and planning of some of the IPE activities that the students had engaged in. The students may therefore have sensed a bias towards IPE in me. It is also important to note that I am a white middle class male in my 50s. All of the students were female, younger than me and one was black. The findings of this study are based on my interpretation of the participants accounts of their experiences. Whilst attempts have been made throughout through reflexivity for me to 'bracket' my own preconceptions and assumptions and interpret the reflections of others in an unbiased, non-judgemental manner without prejudice, it is inevitable that at times my own thoughts and views, informed by my own personal, professional and cultural background and experiences may have influenced my interpretations in some way, shape or form.

The students involved in the study were volunteers and received no payment for being involved in the study, however seeking volunteers for the project may have also resulted in the self-selection of students who had a more positive attitude to IPE. Conversely, it may have selected those who had a more negative attitude and saw this as an opportunity to raise issues.

Finally, attendance at the IPE sessions is a requirement of pre-registration education for the professional programmes represented in the study. Results from interviews with students for whom attendance is a requirement may produce different results than those from interviews with students where attendance is not a requirement.

Despite these limitations new knowledge emerging should be considered to be credible. Many of the findings of this study are also broadly in line with findings from the wider literature.

7.3 Recommendations

7.3.1 Contact

Students clearly benefit from contact and interaction with students from other professions in terms of gaining an insight into, and developing an understanding of, the roles and responsibilities of other

professions. However there is an issue of relevance and students seem to gain more, and engage more with IPE when the students they are working with in IPE activities are drawn from the professions that they currently work with, or are likely to work with in the future. HEIs should consider this when developing IPE activities and allocating students to groups.

7.3.2 Scheduling

Scheduling of IPE is important and affects the experience and engagement. Where the activities are spread throughout the year risks the programme appearing to be disjointed and interrupting the 'flow' and may reduce the credibility of IPE as perceived by the student. However, having one-off core days for IPE activities does not seem to be enough as students seem to want more. It is suggested that when HEIs are developing IPE activities, a balance between spreading the activities and having isolated events be achieved, perhaps as a module delivered over a condensed period of time such as a semester or trimester to maintain focus and encourage engagement.

7.3.3 Role of the Facilitator

The role of the facilitator is a critical factor in IPE. Students respond positively to facilitators who are engaged and enthusiastic and negatively to facilitators who they feel are not motivated, or interested, and perhaps being required to engage in IPE facilitation rather than doing so by choice. HEIs should consider which staff are involved in IPE when allocating work and encourage and develop a group of staff who are interested and motivated in IPE to act as facilitators rather than making it something that staff are required to do. Likewise, the way in which facilitators speak to students and what they say can have a profound effect on the students' experience. This study produced new knowledge to highlight the significance of this. Staff should consider the impact of the words they use and choose them accordingly. Where assessment forms a component of IPE there should be consistency and continuity of facilitators, and facilitator working with students or teaching them should be the one who marks the work.

7.3.4 Setting

IPE happens in a variety of settings and is not confined to the classroom. HEIs should encourage students to recognise the opportunities that exist for IPE and enable these opportunities to be used to their full potential.

7.3.5 Hierarchy

Hierarchy exists both between professional groups and within professional groups and all participants in this study reported experiencing negative interactions where hierarchy was a factor.

However, it was generally perceived by participants that IPE could reduce the impact of hierarchy and positively develop a teamwork ethos within the healthcare professions. HEIs should encourage students to challenge and question hierarchy through IPE activities.

7.3.6 Self Awareness

IPE experiences can increase self awareness amongst students. This study produced new knowledge to highlight the significance of this. Working with students or staff that they would not routinely study or work with provides a unique opportunity to enable students' conduct and behaviour to be highlighted to them in a way which may not normally be achievable when working within their own professional group. Using IPE, HEIs should encourage students to question their own behaviours, conduct and attitudes which may have developed because of personal and or professional background.

7.3.7 Race and Diversity

Race and diversity may be an issue in IPE. The literature reviewed to inform the development and direction of this study did not refer to race, equality or diversity with regard to IPE and there has been no evident discussion of the role that race might play in the experience of IPE by students. This study produced new knowledge to highlight the significance of this. Given that one student in this study highlighted this as being a considerable issue for her, it is likely that it may equally be important for others. Further research is recommended into race, equality, diversity and IPE.

7.4 Summary

This thesis has answered the question 'What are the experiences and perceptions of pre-registration healthcare students of interprofessional education?' and has provided new knowledge to contribute to the understanding of teaching and learning in IPE. New knowledge has emerged with regard to the impact of how facilitators communicate with students during IPE, the extent to which IPE activities can impact on student's self-awareness and the impact that race and diversity may have on the student experience of IPE. Recommendations are made for HEIs to consider when planning IPE, and for further research into race, equality, diversity and IPE.

8.0 Bibliography

Aase, I., Hansen, B. S., Aase, K. and Reeves, S. (2016) 'Interprofessional training for nursing and medical students in Norway: Exploring different professional perspectives', *Journal of Interprofessional Care*, 30(1), pp. 109–115

Afseth, J. D. and Paterson, R. E. (2017) 'The views of non-medical prescribing students and medical mentors on interprofessional competency assessment – A qualitative exploration', *Nurse Education Today*, 52, pp. 103–108

Ajjawi, R. et al. (2009) 'Marginalisation of dental students in a shared medical and dental education programme', *Medical Education,* 43(3), pp. 238–245

Alase, A. (2017) 'The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach', *International Journal of Education and Literacy Studies*, 5(2), pp. 9-19

Allen, D., Baker, T and Rootes, D. (2014) 'Becoming a Nursing and Social Work Student: An Interpretive Phenomenological Analysis of Interprofessional Education'. *Journal of Research in Interprofessional Practice and Education*, 4(1), pp. 2-14

Allport, G. W. (1954). *The nature of prejudice*. Cambridge, Massachusetts: AddisonWesley.

Almås, S. H. and Vasset, F. (2016) 'Health and social care students pursuing different studies, and their written assignments from workshop and online interprofessional education', *Nordic Journal of Nursing Research*, 36(3), pp. 116–121

Alsio, A., Wennstrom, B., Landstrom, B. and Silen, C. (2019) 'Implementing clinical education of medical students in hospital communities: experiences of healthcare professionals'. *International Journal of Medical Education,* 10, pp. 54-61

Bahnsen, I. B., Braad, M., Lisby, H. and Sørensen, I. M. (2013) 'Nursing students' perceptions of taking part in an Inter-professional Clinical Study Unit'. *Nordic Journal of Nursing Research and Clinical Studies / Vård i Norden*, 33(3), pp. 39–43.

Barr, H. (2013) 'Towards a theoretical framework for interprofessional education'. *Journal of Interprofessional Care,* 27, pp. 4–9

Barr, H. and Low, H. (2011) 'Principles of Interprofessional Education'. https://www.caipe.org/resources/publications/barr-low-2011-principles-interprofessional-education [accessed November 2021]

Biggerstaff, D. and Thompson, A. R. (2008) 'Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research'. *Qualitative Research in Psychology*, 5(3), pp. 214-224

Brathwaite, B. (2018) 'Confronting the black, Asian, minority ethnic nursing degree attainment gap', *British Journal of Nursing*, 27(18), pp. 1074–1075

Brown, R. (2000) 'Social identity theory: past achievements, current problems and future challenges', *European Journal of Social Psychology*, 30(6), pp. 745–778

Carpenter, C. (2009) 'Considering the efficacy of Interpretative Phenomenological Analysis (IPA) as a means to reveal teachers' implicit theories of learning'. BERA Research SIG.

Carpenter, J. (1995a) 'Doctors and nurses: Stereotypes and stereotype change in interprofessional education'. *Journal of Interprofessional Care*, 9, pp. 151–161.

Carpenter, J. (1995b) 'Interprofessional education for medical and nursing students: Evaluation of a programme'. *Medical Education*, 29, pp. 265–275.

Carpenter, J., Barnes, D., and Dickinson, C. (2006) 'Outcomes of interprofessional education for Community Mental Health Services in England: The longitudinal evaluation of a postgraduate programme'. *Journal of Interprofessional Care*, 20, pp. 145–161.

Carpenter, J. and Dickinson, C. (2016) 'Understanding interprofessional education as an intergroup encounter: The use of contact theory in programme planning', *Journal of Interprofessional Care*, 30(1), pp. 103–108

Carpenter, J., and Hewstone, M. (1996) 'Shared learning for doctors and social workers: Evaluation of a programme'. *British Journal of Social Work*, 26, pp. 239–257.

Centre for the Advancement of Interprofessional Education (2017) https://www.caipe.org/about-us [accessed November 2021]

Charlick, S., Pincombe, J., McKellar, L., and Fielder, A. (2016) 'Making sense of participant experiences: Interpretative phenomenological analysis in midwifery research'. *International Journal of Doctoral Studies,* 11, pp. 205-216.

Clancy, D., Mitchell, A. and Smart, C. (2020) 'A qualitative exploration of the experiences of students attending interprofessional Schwartz Rounds in a University context'*, Journal of Interprofessional Care*, 34(3), pp. 287–296

Claridge, H., Stone, K. and Ussher, M. (2018) 'The ethnicity attainment gap among medical and biomedical science students a qualitative study', *BMC medical education*, 18(1), pp. 325.

Clarke C (2009) 'An introduction to interpretative phenomenological analysis: a useful approach for occupational therapy research'. *British Journal of Occupational Therapy*, 72(1), pp. 37-39.

Clark, P. (2006). What would a theory of interprofessional education look like? Some suggestions for developing a theoretical framework for teamwork training. Journal of Interprofessional Care, 20, pp. 577–589.

Clark, P. (2009). Reflecting on reflection in interprofessional education: Implications for theory and practice. Journal of Interprofessional Care, 23(3), pp. 213–223.

Colonio Salazar, F. B., Andiappan M., Radford, D. R. and Gallagher J. E. (2017) Attitudes of the first cohort of student groups trained together at the University of Portsmouth Dental Academy towards dental interprofessional education. *European Journal of Dental Education*, 21, pp. 91–100

Collins, A., Brown, J. S., & Newman, S. E. (1988). Cognitive apprenticeship: Teaching the craft of reading, writing and mathematics. *Thinking: The Journal of Philosophy for Children*, 8(1), pp. 2–10.

CoR (2022) https://www.collegeofradiographers.ac.uk/education/clearing2022#Radiography-Careers [accessed September 2022]

Courtenay, M. (2013) 'Interprofessional education between nurse prescribing and medical students A qualitative study', *Journal of Interprofessional Care*, 27(1), pp. 93–95.

Derbyshire, J. A. and Machin, A. I. (2011) 'Learning to work collaboratively: Nurses' views of their pre-registration interprofessional education and its impact on practice', *Nurse Education in Practice*, 11(4), pp. 239–244

Dewey, J. (1933). *How we think: A restatement of the relation of reflective thinking to the educative process*. Boston: Health.

Domac, S., Anderson, L., O'Reilly, M. and Smith, R. (2015) 'Assessing interprofessional competence using a prospective reflective portfolio', *Journal of Interprofessional Care*, 29(3), pp. 179–187

Dominguez, D., Fike, D., MacLaughlin, E. and Zorek, J. (2015) A comparison of the validity of two instruments assessing health professional student perceptions of interprofessional education and practice. *Journal of Interprofessional Care*, 2015; 29(2): pp. 144–149

Evans J.L., Henderson A. and Johnson N.W.(2012) Interprofessional learning enhances knowledge of roles but is less able to shift attitudes: a case study from dental education. European Journal of Dental Education 2012: 16, pp. 239–245.

Francois, J. (2020) 'Storytelling – tales to unlock attainment: One way to address inequality of outcomes for BAME nursing students is to make space for them to explore their experience', *Nursing Standard*, 35(2), pp. 23–24.

Furness, P. J., Armitage, H. R., and Pitt, R. (2012). Qualitative evaluation of interprofessional learning initiatives in practice: Application of the contact hypothesis, *International Journal of Medical Education*, 3, pp. 83–91.

Godbold, R. and Brathwaite, B. (2021) 'Minding the gap. Improving the Black Asian and minority ethnic student awarding gap in pre-registration adult nursing programmes by decolonizing the curriculum', *Nurse Education Today*, 98, pp. 1-3

HCPC (2018) *SET 4.9 – Enabling learners to learn with and from other professions*. Available at: https://www.hcpc-uk.org/globalassets/education/sets-guidance/guidance-for-set-4.9.pdf [accessed November 2021]

Hallin, K. and Kiessling, A. (2016) 'A safe place with space for learning: Experiences from an interprofessional training ward', *Journal of Interprofessional Care*, 30(2), pp. 141-148

Heinemann, G.D., Schmitt, M.H., Farrell, M.P., & Brallier, S.A. (1999). Development of an attitudes toward health care teams scale. *Evaluation & the Health Professions*, 22(1), 123-142.

Hewstone, M. and Brown, R. J. (1986) Contact is not enough: An intergroup perspective on the "contact hypothesis", in Hewstone, M. and Brown, R. J. (eds.) *Contact and conflict in intergroup encounters*. Oxford: Blackwell.

Holland, K., and Rees, C. (2010) *Nursing: evidence-based practice skills*. Oxford: Oxford University Press.

Jones, R., Pietersen, A., Amirthalingam, A. and Chizari, M. (2019). A collaborative reflection on Black, Asian and Minority Ethnic (BAME) attainment in higher education. Available at https://www.researchgate.net/publication/337943846_A_collaborative_reflection_on_Black_Asian_and_Minority_Ethnic_BAME_attainment_in_higher_education [accessed September 2022]

Kaldheim, H. K. A., Fossum, M., Munday, J., Johnsen, K. M. F. and Slettebø, Å. (2021) 'A qualitative study of perioperative nursing students' experiences of interprofessional simulation-based learning', *Journal of Clinical Nursing*, 30, pp. 174–187.

Kelley, A. and Aston, L. (2011) 'An evaluation of using champions to enhance inter-professional learning in the practice setting', *Nurse Education in Practice*, 11(1), pp. 36–40.

Knowles, M. (1984). *Andragogy in Action: applying modern principles of adult learning*. San Francisco: Jossey-Bass.

Kolb, D. (1984). Experiential learning: *Experiences as the source of learning and development*. Englewood Cliffs, New Jersey: Prentice Hall.

Larkin, M and Thompson, A (2012) Interpretative phenomenological analysis, in Thompson, A. and Harper, D. (eds.) *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners.* Oxford: John Wiley & Sons pp. 99-116

Lave, J. and Wenger, E. (1991). *Situated learning Legitimate peripheral participation*. Cambridge, Cambridge University Press.

Leedham-Green, K., Knight, A., and Iedema, R. (2019) 'Intra- and interprofessional practices through fresh eyes: a qualitative analysis of medical students' early workplace experiences', *BMC Medical Education* 19(287), pp. 2-9

Lindqvist, S., Duncan, A., Shepstone, L., Watts, F., and Pearce, S. (2005) 'Case-based learning in cross-professional groups—The development of a pre-registration interprofessional learning programme', *Journal of Interprofessional Care*, 19, pp. 509–520.

Marcussen, M., Nørgaard, B. and Arnfred, S. (2019) 'The effects of interprofessional education in mental health practice: findings from a systematic review', *Academic Psychiatry*, 43, pp. 200–208

Mann, S. (2016) '*The research interview : reflective practice and reflexivity in research processes*' Basingstoke: Palgrave Macmillan

McFadyen, A. K., Maclaren, W. M., & Webster, V. S. (2007). The Interdisciplinary education perception scale (IEPS): An alternative remodelled sub-scale structure and its reliability. Journal of Interprofessional Care, 21, pp. 433–443

Memon, A. R. and Jivraj, S. (2020) 'Trust, courage and silence: carving out decolonial spaces in higher education through student-staff partnerships', *Law Teacher*, 54(4), pp. 475–488

Michalec B, Giordano C, Dallas S, and Arenson C. (2017) 'A longitudinal mixed methods study of IPE students' perceptions of health profession groups: revisiting the contact hypothesis'. *Journal of Interprofessional Education and Practice*, 6, pp. 71–79.

Mohaupt, J., van Soeren, M., Andrusyszyn, M.-A., MacMillan, K., Devlin-Cop, S., and Reeves, S. (2012) 'Understanding interprofessional relationships by the use of contact theory'. *Journal of Interprofessional Care,* 26, pp. 370–375.

Monrouxe, L. V., Rees, C. E., Endacott, R. and Ternan, E. (2014) '"Even now it makes me angry": health care students' professionalism dilemma narratives' *Medical Education,* 48, pp. 502–517

Nardella, M.S., Carson, N.E., Colucci, C.N., Corsilles-Sy, C., Hissong, A.N. and Simmons, D. (2018) 'Importance of Collaborative Occupational Therapist--Occupational Therapy Assistant

Intraprofessional Education in Occupational Therapy Curricula', American Journal of Occupational Therapy, 72, pp. p1–p18

NMC (2021) *Standards framework for nursing and midwifery education*. Available at: https://www.nmc.org.uk/standards-for-education-and-training/standards-framework-for-nursing-and-midwifery-education/ [accessed November 2021]

O'Carroll, V., McSwiggan, L. and Campbell, M. (2016) 'Health and social care professionals' attitudes to interprofessional working and interprofessional education: A literature review', *Journal of Interprofessional Care*, 30(1), pp. 42–49.

Osman, A. (2017) 'What makes medical students receptive to interprofessional education? Findings from an exploratory case study', *Journal of Interprofessional Care,* 31(5), pp. 673–676.

Parsell, G. and Bligh, J. (1999) 'The development of a questionnaire to assess the readiness of health care students for interprofessional learning (RIPLS)', Medical Education, 33(2), pp. 95–100

Pettigrew, T. F. (1998) 'Intergroup contact theory'. *Annual Review of Psychology*, 49, pp. 65–85.

Reid, K., Flowers, P. and Larkin, M (2005) 'Exploring lived experience; An introduction to Interpretative Phenomenological Analysis'. *The Psychologist*, 18, pp. 20-23

Ritchie, C., Dann, L. and Ford, P. (2013). Shared learning for oral health therapy and dental students: enhanced understanding of roles and responsibilities through interprofessional education. *European Journal of Dental Education:* 17: 56–63.

Roberts, T. (2013) 'Understanding the research methodology of interpretative phenomenological analysis'. *British Journal of Midwifery*, 21(3), pp. 215-218

Roberts, F. E. and Goodhand, K. (2018) 'Scottish healthcare student's perceptions of an interprofessional ward simulation: An exploratory, descriptive study', *Nursing and Health Sciences*, 20(1), pp. 107–115.

Schon, D. (2016) *The reflective practitioner : how professionals think in action.* Abingdon, Routledge.

Sciascia, A., Christopher, K., Humphrey, C., Simpkins, L., Page, C.G. and Jones, L.G. (2021) 'Test/Re-Test reliability of the readiness for interprofessional education learning scale and interdisciplinary education perception scale in health science students', *Journal of Interprofessional Care*, 35(1), pp. 114–123

Smith, J.A., Flowers, P. and Larkin, M. (2012) *Interpretative phenomenological analysis: Theory, method and research.* London, Sage Publications Ltd.

Starks, H. and Brown Trinidad, S. (2007) 'Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory', *Qualitative Health Research*, 17(10), pp. 1372-1380

Stephens, M. and Ormandy, P. (2018) 'Extending conceptual understanding: How interprofessional education influences affective domain development'*, Journal of Interprofessional Care*, 32(3), pp. 348–357

Strayorn, T. L. (2018). *College Students' Sense of Belonging. A Key to Educational Success for All Students*. 2nd ed. New York: Imprint Routledge.

Tajfel, H., & Turner, J.C. (1986). The social identity theory of intergroup behavior. In S. Worchel, L.W. Austin (Eds.), Psychology of Intergroup Relations (pp. 7–24). Chicago: Nelson-Hall.

Telford, M. and Senior, E. (2017) 'The experiences of students in interprofessional learning'. *British Journal of Nursing,* 26(6), pp. 350-354

Teheux, L., Coolen, E.H.A.J., Draaisma, J.M.T., de Visser, M., Scherpbier-de Haan, N.D., Kuijer-Siebelink, W. and van der Velden, J. A. E. M. (2021) Intraprofessional workplace learning in postgraduate medical education: a scoping review. BMC Med Educ 21, 1, pp. 1-5

Thistlethwaite, J. (2012) 'Interprofessional education: A review of context, learning and the research agenda'. *Medical Education*, 46, pp. 58–70.

Tran, C., Kaila, P. and Salminen, H. (2018) 'Conditions for interprofessional education for students in primary healthcare: a qualitative study'. *BMC Medical Education*, 18, pp. 1-8

Universities UK (2019) *Black, Asian and Minority Ethnic Student Attainment at UK Universities: #closing the gap*. Available at: https://www.universitiesuk.ac.uk/sites/default/files/field/downloads/2021-07/bame-student-attainment.pdf [Accessed November 2021]

Wenger, E. (1998). *Communities of practice: learning, meaning and identity.* Cambridge: Cambridge University Press.

Whiting L, Caldwell C, Akers E (2016) 'An examination of interprofessional education in a pre-registration children's nursing course'. *Nursing Children and Young People,* 28(6), pp.22-27

WHO (2010) *Framework for action on interprofessional education and collaborative practice*. Available at: http://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf;jsessionid=1C1860DD1A8D4A15950A67AB4319A4F1?sequence=1 [Accessed November 2021]

Williamson, G. R., Callaghan, L., Whittlesea, E., Mutton, L. and Heath, V. (2011) 'Placement Development Teams and interprofessional education with healthcare students', *Journal of Clinical Nursing*, 20, pp. 2305–2314

World Health Professions Alliance (2019) *WHPA statement on interprofessional collaborative practice.* Available at: https://www.whpa.org/news-resources/statements/whpa-statement-interprofessional-collaborative-practice [Accessed November 2021]

Wright, A., Hawkes, G., Baker, B. and Lindqvist, S. M. (2012) 'Reflections and unprompted observations by healthcare students of an interprofessional shadowing visit', *Journal of Interprofessional Care,* 26 (4), pp. 305–311

Yoo, J.-H. and Kim, Y.-J. (2018) 'Factors Influencing Nursing Students' Flow Experience during Simulation-Based Learning', *Clinical Simulation in Nursing*, 24, pp. 1–8.

Appendix 1

Summary of the papers included in the review

Article	Year	Country	Method
Aase, I., Hansen, B. S., Aase, K. and Reeves, S. (2016) 'Interprofessional training for nursing and medical students in Norway: Exploring different professional perspectives', *Journal of Interprofessional Care*, 30(1), pp. 109–115	2016	Norway	focus groups and individual interviews and field observations
Afseth, J. D. and Paterson, R. E. (2017) 'The views of non-medical prescribing students and medical mentors on interprofessional competency assessment – A qualitative exploration', *Nurse Education Today*, 52, pp. 103–108	2017	UK	semi-structured interviews and focus groups
Allen, D., Baker, T and Rootes, D. (2014) 'Becoming a Nursing and Social Work Student: An Interpretive Phenomenological Analysis of Interprofessional Education'. *Journal of Research in Interprofessional Practice and Education*, 4(1), pp. 2-14	2014	UK	Individual interviews/IPA
Almås, S. H. and Vasset, F. (2016) 'Health and social care students pursuing different studies, and their written assignments from workshop and online interprofessional education', *Nordic Journal of Nursing Research*, 36(3), pp. 116–121	2016	Norway	narrative analysis
Alsio, A., Wennstrom, B., Landstrom, B. and Silen, C. (2019) 'Implementing clinical education of medical students in hospital communities: experiences of healthcare professionals'. *International Journal of Medical Education,* 10, pp. 54-61	2019	Sweden	focus groups
Bahnsen, I. B., Braad, M., Lisby, H. and Sørensen, I. M. (2013) 'Nursing students' perceptions of taking part in an Inter-professional Clinical Study Unit'. *Nordic Journal of Nursing Research and Clinical Studies / Vård i Norden*, 33(3), pp. 39–43	2013	Denmark	Focus Group
Clancy, D., Mitchell, A. and Smart, C. (2020) 'A qualitative exploration of the experiences of students attending interprofessional Schwartz Rounds in a University context'*, Journal of Interprofessional Care*, 34(3), pp. 287–296	2020	UK	Individual interviews/IPA
Courtenay, M. (2013) 'Interprofessional education between nurse prescribing and medical students A qualitative study',	2013	UK	Focus Groups

Journal of Interprofessional Care, 27(1), pp. 93–95			
Derbyshire, J. A. and Machin, A. I. (2011) 'Learning to work collaboratively: Nurses' views of their pre-registration interprofessional education and its impact on practice', *Nurse Education in Practice*, 11(4), pp. 239–244	2011	UK	Individual interviews
Domac, S., Anderson, L., O'Reilly, M. and Smith, R. (2015) 'Assessing interprofessional competence using a prospective reflective portfolio', *Journal of Interprofessional Care*, 29(3), pp. 179–187	2015	UK	narrative analysis and semi structured interviews
Hallin, K. and Kiessling, A. (2016) 'A safe place with space for learning: Experiences from an interprofessional training ward', *Journal of Interprofessional Care*, 30(2), pp. 141-148	2016	Sweden	narrative analysis
Kaldheim, H. K. A., Fossum, M., Munday, J., Johnsen, K. M. F. and Slettebø, Å. (2021) 'A qualitative study of perioperative nursing students' experiences of interprofessional simulation-based learning', *Journal of Clinical Nursing*, 30, pp. 174–187	2021	Norway	focus groups
Kelley, A. and Aston, L. (2011) 'An evaluation of using champions to enhance inter-professional learning in the practice setting', *Nurse Education in Practice*, 11(1), pp. 36–40	2011	UK	narrative analysis
Leedham-Green, K., Knight, A., and Iedema, R. (2019) 'Intra- and interprofessional practices through fresh eyes: a qualitative analysis of medical students' early workplace experiences', *BMC Medical Education* 19(287), pp. 2-9	2019	UK	Narrative analysis
Marcussen, M., Nørgaard, B. and Arnfred, S. (2019) 'The effects of interprofessional education in mental health practice: findings from a systematic review', *Academic Psychiatry*, 43, pp. 200–208	2019	Denmark	Lit Review
Monrouxe, L. V., Rees, C. E., Endacott, R. and Ternan, E. (2014) '"Even now it makes me angry": health care students' professionalism dilemma narratives' *Medical Education,* 48, pp. 502–517	2014	UK	narrative analysis
O'Carroll, V., McSwiggan, L. and Campbell, M. (2016) 'Health and social care professionals' attitudes to interprofessional working and interprofessional education: A	2016	UK	Lit Review

literature review', *Journal of Interprofessional Care*, 30(1), pp. 42–49			
Osman, A. (2017) 'What makes medical students receptive to interprofessional education? Findings from an exploratory case study', *Journal of Interprofessional Care,* 31(5), pp. 673–676	2017	UK	Focus Groups
Roberts, F. E. and Goodhand, K. (2018) 'Scottish healthcare student's perceptions of an interprofessional ward simulation: An exploratory, descriptive study', *Nursing and Health Sciences*, 20(1), pp. 107–115	2018	UK	Focus Groups
Stephens, M. and Ormandy, P. (2018) 'Extending conceptual understanding: How interprofessional education influences affective domain development'*, Journal of Interprofessional Care*, 32(3), pp. 348–357	2018	UK	Action Research/Focus Groups
Telford, M. and Senior, E. (2017) 'The experiences of students in interprofessional learning'. *British Journal of Nursing,* 26(6), pp. 350-354	2017	UK	Focus Groups
Tran, C., Kaila, P. and Salminen, H. (2018) 'Conditions for interprofessional education for students in primary healthcare: a qualitative study'. *BMC Medical Education*, 18, pp. 1-8	2018	Sweden	focus groups
Whiting L, Caldwell C, Akers E (2016) 'An examination of interprofessional education in a pre-registration children's nursing course'. *Nursing Children and Young People,* 28(6), pp.22-27	2016	UK	Focus Groups
Williamson, G. R., Callaghan, L., Whittlesea, E., Mutton, L. and Heath, V. (2011) 'Placement Development Teams and interprofessional education with healthcare students', *Journal of Clinical Nursing*, 20, pp. 2305–2314	2011	UK	telephone interviews and focus groups
Wright, A., Hawkes, G., Baker, B. and Lindqvist, S. M. (2012) 'Reflections and unprompted observations by healthcare students of an interprofessional shadowing visit', Journal of Interprofessional Care, 26 (4), pp. 305–311	2012	UK	narrative analysis

Appendix 2

Participant Information Sheet

An Interpretive Phenomenological Analysis of Interprofessional Education; An investigation of the experiences of pre-registration healthcare students

PARTICIPANT INFORMATION SHEET

A research study is being conducted at Canterbury Christ Church University (CCCU) by Mark Gradwell

Background

This study forms part of a Doctorate in Education and will investigate the way in which pre- registration healthcare students experience interprofessional education (IPE). The study will involve pre-registration healthcare students at CCCU in two different year groups who have experienced IPE delivered in different ways. Individual interviews will be held with a small number of consenting selected participants twice during the research study. Interviews will be recorded and transcribed. Transcripts will be analysed, and emerging themes will be explored.

What will you be required to do?

Participants in this study will be required to participate in two interviews. These interviews will be held at CCCU. The second interviews will take place around 9 months after the first interview. If you decide to participate you will be asked about your availability prior to the interviews to arrange a mutually convenient location and time, and will receive these details either by telephone or email. The discussion in these interviews will centre on your experiences of interprofessional education. It is anticipated that the interviews will take no longer than an hour. The will be recorded and you will be given the opportunity to see a transcript of the interview afterwards to verify the content.

To participate in this research you must:

- Be a preregistration student in the Faculty of Health and Wellbeing at CCCU
- be in the April 17 or September 17 cohort.

Procedures

You will be asked to participate in two interviews. These interviews will be held at CCCU. The second interviews will take place around 9 months after the first interview. The discussion in these interviews will centre on your experiences of interprofessional education. It is anticipated that the interviews will take no longer than an hour.

Feedback

The interviews will be recorded and you will be given the opportunity to see a transcript of the interview afterwards to verify the content. You can ask for the findings from the study if they wish to see them.

Confidentiality and Data Protection

On the legal basis of consent all data and personal information will be stored securely within CCCU premises in accordance with the General Data Protection Regulation (GDPR) and the University's own data protection policies. No unrelated or unnecessary personal data will be collected or stored. Any documentation identifying each participation (eg.initial e-mail communication, consent to participate etc.will be kept on a password-protected computer. Any identifiable data will be kept separately from

Appendix 3

Consent Form

CONSENT FORM

Title of Project: An Interpretive Phenomenological Analysis of Interprofessional Education; An investigation of the experiences of pre-registration healthcare students

Name of Researcher: Mark Gradwell

Contact details:

Address: Faculty of Health and Wellbeing
Canterbury Christ Church University,
Rowan Williams Court, Universities of Medway Campus, 30 Pembroke Court
Chatham Maritime
Kent
ME4 4UF

Tel: 01227 924427

Email: mark.gradwell@canterbury.ac.uk

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	
3. I understand that any personal information that I provide to the researchers will be kept strictly confidential	
4. I agree to take part in the above study.	
5. I agree to my interviews being audio recorded	

Name of Participant:	Date:	Signature:
Name of person taking consent *(if different from researcher)*	Date:	Signature:
Researcher:	Date:	Signature:

Copies: 1 for participant
1 for researcher

Appendix 4

Interview schedule

The interviews will be semi structured to allow an in depth exploration of topics. The interview schedule will be used to ensure internal consistency, however the schedule will not be followed in any particular order and participants will be encouraged to discuss topics that they feel are important. Interviews will be recorded, transcribed and returned to the interviewee for verification and an opportunity to clarify any points.

Semi-structured interview schedule

- What has been your experience of participating in IPE during the pre-registration programme you are studying on?
- What do you think IPE was/is trying to achieve?
- Was/is IPE effective in achieving these aims?
- What was/is good about IPE?
- Have you got an example of excellence in IPE?
- What was/is negative about IPE?
- Was/is the content of the IPE appropriate to the professional discipline you are studying?
- What do you feel engaged/did not engage you in IPE?
- What did you learn/are you learning from IPE?
- What are your attitudes to IPE?
- Have your attitudes to IPE changed over time - if so what has changed them?
- Would you make any recommendations for improvement in IPE?
    - How should it be organised?
    - What should be addressed?
- 'Do you think healthcare students / professionals are 'encouraged' to view other healthcare professionals in a particular way? If so, why do you think this is the case? If not, why not?
- Does hierarchy between healthcare professions exist?
- Does hierarchy impact on how professions work together?

Appendix 5

Example of Transcript Analysis

	BETH – Interview 1	Descriptive Comments Linguistic Comments Conceptual Comments
Emergent Themes	Original Transcript	Exploratory Comments
Contact Learn from/about others roles	MG: [00:00:04] Could just tell me, what's been your experience of Interprofessional Education, during the programme that you've been on? Beth: [00:00:14] I think we've had different types. We've had structured ones at university. But you get learning experiences don't you on placement. The first years... Sorry, I don't know who organised that ... I found less helpful than second years - I loved the structure of this year's interprofessional education because we were at tables and we all had conversation. And I think that was very authentic. And we got to learn about, you know, the roles that these people do. I didn't know what ODPs particularly did, or how nurses felt about midwives or whatever. There was no conversation like that in the first year as it was in the lecture theatre... erm ... it was good. We learned a lot, but I think I got a lot more personally out of second year. And then obviously doing, doing it in, on placement. It's very different because you're you already working with these people and you, they have their roles and you have yours. So I think they're very different, aren't they. MG: [00:01:18] So what was your experience on placement?	Sorry – apologises for not having positive view of first year experience I loved …… authentic – very positive about second year experience we got to learn about, you know, the roles that these people do. Positive about second year – less so about first year although acknowledged learning took place Differentiated between learning in uni and on placement

Hierarchy and status - between professions Hierarchy and status - between professions – based on knowledge and experience	[00:01:22] So with theatre staff, when a lady goes through caesarean or whatever you work, you work with obstetricians and other students, and midwives and stuff on the delivery suite anyway. And I find there can be some hierarchy, especially with the obstetricians. Not so much within theatre, I find theatre staff, very welcoming and very accommodating, and happy to talk you through procedures that, you know, I don't know about layers of caesarean sections, I don't have to do that, but the theatre staff would talk you through that, so yeah, that's kind of on the acute setting. And then I'm on community at the minute and we have... we deal with, like, social services. We have not a lot of .. well, it seems to be a lot of involvement with social services at the minute..... Photocopying notes and having discussions about women's safety and baby safety and stuff. Yeah, they, um, my mentor was quite keen for me to sit in on multidisciplinary meetings and things, which is kind of on the job learning, and it's nice to see those conversations and how well the teams work together and how cohesive it is. MG: [00:02:31] You mentioned hierarchy. And so do you... Do you think there's a hierarchy that exists between health care professionals? Beth: [00:02:40] I think to some extent there needs to be. I think it helps the teams run well. I know I don't perform forceps deliveries... I know I can trust the doctors to do that. In those	Specific mention of obstetricians Differentiated between settings – theatre and delivery suite Differentiated between settings – acute and community nice to see those conversations and how well the teams work together and how cohesive it is. Positive examples of collaborative working described I can trust the doctors to do that

Hierarchy and status - between professions – attempts to breakdown/breach Hierarchy and status - between professions – feeling of intimidation Hierarchy and status - between professions – based on role	situations, I think it's quite helpful because everybody's got their own limits of practice. Some of the doctors... Yes... Do have an air of superiority, I guess, But that's that's very rare. It's on very rare occasions. I find mentors are very keen to be like, this is my student, and kind of... not break down the hierarchy, but kind of breach that gap. Yeah. MG: [00:03:19] And do you think that hierarchy impacts on how we work together? Beth: [00:03:25] I think so. Yeah, I think sometimes it can be... I mean, not in the good circumstances like the scope of practice... But personally, that was the first time I'd ever done a handover to a doctor... And he was very intimidating and kind of shot me down and picked holes in everything, and had a kind of smugness. My mentor commented on it. And that made me very apprehensive about doing it again, like, the next time I was doing it, my mentor made sure it wasn't to, you know, this this this doctor, And I said, actually, he doesn't work there anymore. He was like a bank, like on on-call obstetrician registrar. MG: [00:04:07] You said, "not in a good way, like, with the scope of practice. What did you mean by that? [00:04:14] I think just... well you need to know your role don't you.. So I'm going to hopefully	Doctors can exploit presumed status to intimidate other staff very apprehensive about doing it again

Learn from/about others roles	one day be a midwife. I know what that job entails. I know... I know what my my role is within that team. Theatre, They know what their role is within that team, I wouldn't presume to go into theatre and know where all of the equipment is, same as they wouldn't come in and presume to know how to do a vaginal examination. Sometimes I think it's not really a hierarchy, though, is it? That's not... That's a different kind of thing. It's not .. senior midwife ... maybe that's a better...erm.. I don't know how the delivery suite runs, I don't know. I have a lot of respect for the midwife that co-ordinates, erm... She's in charge, but she treats us like a team rather than, you know. this is you, and this is me. I think that's a good way, that's what I mean, when they work nicely, in teams together. MG: [00:05:11] So, do you think that the student healthcare professionals are encouraged to view other Healthcare professionals in a particular way. [00:05:30] Kind of... Sometimes you hear people say, oh, the midwives are snobby or the nurses are lazy or like, oh, My God I was on SCBU and it was so boring cos they don't do anything. Actually, I think that's just hearsay. And that's your own prejudices. I think certainly education wise, and every mentor I've had, and the interprofessional collaboration learning thing that we did, that was all aimed at kind of pulling us together and an appreciation and a respect,	I wouldn't presume to know someone elses role same as they wouldn't presume to know mine Questions concept of Hierarchy Seems to differentiate between hierarchy and seniority when they work nicely, in teams together. That's your own prejudices acknowledge that stereotypes exist due to 'hearsay' Based on appreciation and respect

Contact	which is what I liked, I think that's why I got more out of the second year than I did out the first year. There wasn't really any mingling in the first year. [00:06:11] Okay, so what is it then that you think interprofessional education is trying to achieve? [00:06:17] I think just that, I think, I've read a lot of papers. You see that the RCN do it all the time, and the RCOG about how, learning together then breaks down those those hierarchies and prejudices. And then you get more cohesive teams and better outcomes for women and staff, and less burnout and you're sharing the burden and appreciating each other a bit more. So I guess it's, I hope, my understanding is that's what it's for. MG: [00:06:46] And do you think it's effective in achieving that, from your experiences? [00:06:47] I think so. I mean, I always try and be nicer than I need to be anyway as a person in general in my whole life. But when you're educated, like I'd never had a chance to sit down with a student nurse and find out their hours and their shifts, or an ODP and find out, you know, do you go out on placement? Do you have this? Do you... You know what's your... How do you learn how do they grade you, and I found that really helpful because you kind of get an appreciation for what they're going through, whereas they	Contact with other professions is important Refers to better outcomes for service users through collaboration Contact with other professions is important
Learn from/about others roles Hierarchy and status - between professions – attempts to breakdown/breach Collaborative Practice - Better Outcomes		
Learn from/about others roles and practice		

Contact	kind of thought.. One of them said that they thought the midwives were really kind of up themselves and didn't realise that actually we had such big long blocks of placement and then big blocks long blocks of uni. I think it's just an appreciation for other people's workload that you get when you're having authentic conversations like that. So, yeah, I think definitely. MG: [00:07:43] So if you if you had to, sort of say, what you thought was good about IPE, what would that be then?	authentic conversations
Learn from/about other's roles and practice	Beth: [00:07:49] The opportunity to mix with people from other disciplines, because we don't... we, even amongst the midwives, we don't see the Canterbury lot very much, we don't have any.. outside of those IPE days... We don't have any involvement with anybody else, really. and I think it was really.. It was NICE just to have a conversation and to appreciate the journey that everybody else is on. I think it's quite easy to get isolated in your own professions. But then to hear them training and their passions was quite like, wow, you know, that's that's amazing. It's amazing that you feel that way about that. And to see their passion, then kind of gives everybody else a bit more respect for it, I think MG: [00:08:30] So. If you, If you... Have you got any examples of.. you mentioned that day... in terms of excellence in IPE, have you come across	Contact with other professions is important Stressed word 'nice' – positive and pleasant experience to see their passion, then kind of gives everybody else a bit more respect

Collaborative Practice	a specific incident that you thought that was a really good example of interprofessional education? Beth: [00:08:53] Maybe the first time I saw Neonatal Resus... terrifying. I was Terrified. I mean, it's fine doing training at uni, but nothing prepares you for that moment... And a midwife brought out a blue floppy baby, took it to the Resuscitaire, The CSWs are amazing... this was at the birth centre, so low risk, no obstetricians on site ... And everybody just popped into action. It was like the most cohesive teamwork I've ever seen. And I thought, wow. Actually, it was my whole... I thought it was a really positive learning experience. Scary, but positive. But the CSWs phoned the ambulance. The ambulance was there very quickly. The.. The paramedics and the midwives worked very well together. Phone calls were made to, you know, for transfers and things. There was kind of an effortless handover..... And I think unless you were really, really watching, you couldn't see when the paramedics took over care. It was kind of just, very, it was a lovely teamwork dynamic, really lovely. And I kind of went away from that thinking "That's how it needs to be. When there's no "Oh it's the paramedics" or "The midwives are get..." Like, it was just lovely to see them working so well together. I think that was my first wow moment of a multi professions. Yeah..	Described an experience on practice placement as interprofessional education because she observed teamwork and collaborative practice in action I thought it was a really positive learning experience. it was a lovely teamwork dynamic I kind of went away from that thinking “That’s how it needs to be I think that was my first wow moment of a multi professions.

IPE is a positive experience	MG: [00:10:21] Anything negative you come across in IPE? Beth: [00:10:23] No, I don't... I think I've been quite lucky. I think.. That one grumpy doctor, but everybody said he was actually... He was grumpy.... This is how he always is, we had issues with him before. So maybe that was just him as a person, rather than a professional thing.... No, I don't think I have. Sorry.... MG: [00:10:49] Is the... Is the context of Interprofessional education that you've experienced so far..do you think that's appropriate to what it is that you're studying - the topic area, the subject area that you're studying?	was just him as a person, rather than a professional thing Differentiated between personal and professional behaviour
IPE is a positive experience – relevant	MG: [00:11:00] Yeah, yeah, I really enjoyed it, because they are people that we will come across in our.. in our jobs. Hopefully jobs .... we will see nurses and we will see paramedics and I don't know who who else was there - mental health, wasn't it? Yes. So we will see these people. We'll be working with them. I think it's nice to have that ... like I said before, the appreciation of their journey and their passions.	because they are people that we will come across in our.. in our jobs
Learn from/about other's roles and practice	[00:11:29] And the way you're talking at the moment about IPE and about collaborative practice, You seem quite engaged. What is it that engages you?	I think it's nice to have that ... like I said before, the appreciation of their journey and their passions.

Professional Pride Collaborative practice IPE is a positive experience Contact	[00:11:43] I like to talk to people. I like to find out what they enjoy. And seeing somebody have passion for their career is quite nice. And I think we got that. I was just on a lucky table of people who were willing to have a conversation. There was a very open conversation. I enjoyed that a lot. Other than that, I've read about the outcomes and how it can be better for everybody involved and for the professionals as well to not, you know, to feel like a valued team member. I think there's a lot of research on that, isn't there, about how it .. It makes better teams. And I don't see what could be negative about it, really. I don't see what could be wrong with it. I can't see any negatives. MG: [00:12:29] So other than the ... 'Being together', being with somebody from another professional group, what did you think you learned or are you learning from interprofessional education, I mean, you've talked a lot about how important that is. Just just meeting people. Beth: [00:12:49] Yes MG: [00:12:49] Tell me what you think you're actually learning from it. Beth: [00:12:55] Loads of stuff...It's hard to just say one thing.	seeing somebody have passion for their career is quite nice To feel like a valued team member. It makes better teams. And I don't see what could be negative about it, really. I don't see what could be wrong with it. I can't see any negatives. Just having contact with people from other professions clearly important to her Found it difficult to specify what she was actually learned from IPE

	MG: [00:12:57] Well, tell me about loads of stuff then...	
Learn from/about other's roles and practice Collaborative practice Learn from/about other's roles and practice Contact	Beth: [00:13:07] I don't know.... I now, know that, the ODPs say they can't do obstetric emergencies, that they hope that midwives come before that lady or the baby dies. I think there's trust there that we work together. And when things go bad, we're in it together. I think it's nice to.... know the training, I guess, that other people have been through, because then when you see, like when I attend on Tuesday, I think, I'm going to a meeting with social services and the mental health midwife to discuss the care of a lady. And it's nice to know, kind of, their backgrounds and maybe where they've come from and what they deal with and to have conversations that then create safety for this lady.	I think there's trust there that we work together. And when things go bad, we're in it together.
Collaborative Practice - Teamwork Professional Pride Collaborative Practice - attempts to breakdown/breach barriers	Beth: [00:14:12] I think I'm learning how to be a better team player, I guess, and to have that respect for.... everybody - everybody has a role to play and everybody loves their job and they've picked that job for a reason, always something behind it, there's a reason why you're a mental health nurse and not a pediatric nurse, or why you decided to do ODP rather than going to be a doctor. But there's always a reason.... erm.. and I think it's so easy to stop thinking of everybody else as people. I think sometimes we isolate ourselves and it's nice to see.... nice to bring that together... And enforce that you are a TEAM, everybody, rather than we are a team of	I think I'm learning how to be a better team player everybody loves their job and they've picked that job for a reason I think sometimes we isolate ourselves and it's nice to see.... nice to bring that together... And enforce that you are a TEAM, everybody, rather than we are a team of midwifes, or a team or

Collaborative Practice – respect Collaborative Practice – Cohesion	midwifes, or a team or whatever from an early stage, because then you have a better respect for them. And it's not like, oh, my God, I did that sort of thing with her and they still haven't got back today. No, actually, you know, they're probably really busy. They've got all this paperwork, they've done this, they love their jobs and they're doing it because blah, blah, and I think it stops, not tensions because there's always going to be something, whatever, I think it just helps it to be a little more cohesive. Erm.. What was the question? Remind me.... MG: [00:15:28] The kind of things you've learnt.... Beth: [00:15:32] So, yeah, I think that's sums it up really.... MG: [00:15:36] And do you think that that idea of what you were talking about there, about tensions between the professions ... perhaps... talking about working in silos... Do you think that the interprofessional experiences that you've had... well, turn on its head, if you hadn't had those interprofessional experiences, would that have helped or hindered or do you think you would have got there in the end? Beth: [00:16:05] I think you get there in the end. But I don't think that necessarily means the best outcomes for people you're caring for in the meantime. I think hospital is enough of a culture	whatever from an early stage, because then you have a better respect for them. Emphasis on word team and use of word respect it stops, not tensions because there's only going to be something, whatever, I think it just helps it to be a little more cohesive. Use of word cohesive

Learn from/about other's roles and practice	shock anyway, but going into it, knowing the sort of people you're going to be working with, is beneficial... I think it would've been a hindrance in all honesty...erm.. I don't know what community nurses do or what ODPs do. I don't know about their... They spent six months on ambulances in their time... That's that's incredible to me.. I just... I don't know, I think it gives it has given me a big appreciation for what they've done to get to where they are now and... It's not just us, like we think, our course is hard but theirs is too, and, you know, we're all on the same journey, essentially. We all want the same things. And I think that was one of the main things, is that as long as we can all do our jobs and work well together, we all want to go to bed at night knowing that we've done the best we can and worked to the best that we can, and, and that was the real kind of theme, running through all of the education. So, yeah, I think not having that, you can just, I don't know, yeah, I think it would be detrimental definitely. MG: [00:17:24] Have your opinions of other professions, changed? Beth: [00:17:31] From first year to second year, Yeah, I think so. MG: [00:17:33] Or even before you came onto the programme.	knowing the sort of people you're going to be working with, is beneficial
Learn from/about other's roles and practice		I think it gives it has given me a big appreciation for what they've done to get to where they are now
Collaborative Practice – Teamwork		we're all on the same journey, essentially. We all want the same things.
Collaborative Practice – Teamwork		as long as we can all do our jobs and work well together, we all want to go to bed at night knowing that we've done the best we can and worked to the best that we can, and, and that was the real kind of theme, running through all of the education.

Collaborative Practice – respect Contact Eroding Stereotyping Breaking down barriers	Beth: [00:17:40] Errr..I guess, yeah. Probably. We did alternative placement in the first year and I had a nursing block, like acute nursing and that's incredibly difficult ... the depth of their knowledge on things like drugs and procedures and whatever was INCREDIBLE, And I looked and thought actually I don't think I could ever do, I don't think I could ever be a nurse. and they said the same about us, The ODPs... I'm sorry ODPs, in the first year, in the first year, IPE were very separate, and very kind of, they kept to their own little group and didn't particularly want to talk to anybody else, and I think that made everybody else a bit like, OK so it's us and you then. Second year, there was none of that. Maybe it is because the structure of things, I dont know, But we were very much a group from the beginning. So much so that when we went into the afternoon sessions, we sat together again. Regardless of the fact that there was more of the people from our own cohorts in the room. So it was quite nice, and we see them on campus and it's like 'Hi!'. So I think my own perceptions have changed a little bit - Not I like to admit that I had preconceived ideas (laughs) MG: [00:19:01] It's OK, you can admit to that, I'm just interested in what they might have been. Beth: [00:19:06] Erm.. I think I thought it was more separate than it is, before I joined the uni. I didn't realize there was that kind of level of, I guess community amongst health care providers,	the depth of their knowledge on things like drugs and procedures and whatever was INCREDIBLE stress on word incredible respect for others seems evident - I don't think I could ever be a nurse but this comes from respect rather than a derogatory judgement Where a profession does not engage, judgements are made about the profession as a whole think my own perceptions have changed a little bit - Not I like to admit that I had preconceived ideas – laughs about this but suggestion of pre-concieved stereotyping/judging

Eroding stereotyping Eroding stereotyping Collaborative Practice - attempts to breakdown/breach barriers	I didn't realize that was a thing, and that the roles, not overlapped, but like they so gently rely on each other knowing what you're doing, like, the boundaries are very respectful of each other. And I didn't realize that was a thing... and then I'd heard, I'd heard, some not so nice things about attitudes of other people, particularly towards midwives, actually I must admit, erm, how people thought midwives were better than, I don't know, because we're more specialized or whatever...erm.. So I kind of am fighting to not have that stigma and to not be that bad team member that is then, feels like I'm better, because it's not, it's so NOT like that. So it makes me sad that those ideas have been out there in someway. MG: [00:20:18] Tell me about some of those things you'd heard then, because your face was like, I don't really want to talk about that... Beth: [00:20:22] No, Because it makes me really sad that that's even a thing. We had heard that the ODPs were very separate and that they didn't particularly like the midwives coming into their space. And then I suppose the first year IPE kind of cemented that. Maybe that's why we were on edge a little bit... erm, yeah, I think, I think that's why the IPE was so good in the second year, really really enjoy that. [00:20:56] You mentioned that quite a lot about the difference in the IPE in the first year and the	Evidence of changing of perceptions about working in silos - refers to a community amongst health care providers and says they so gently rely on each other I'd heard, some not so nice things about attitudes of other people, particularly towards midwives ….. So I kind of am fighting to not have that stigma and to not be that bad team member Determination not to live up to negative image it's not, it's so NOT like that. So it makes me sad that those ideas have been out there in someway. Emphasis on word 'not' and despription of how it makes her sad that these suggestions exist it makes me really sad that that's even a thing Evidence of change of view from first year to second year as contact with members from other profession (ODPs) increased

	second year, so just tell me what was different about it, and why it had that different outcome	
Contact Requires engagement Contact Requires engagement Contact	[00:21:03] Well, the first day we were in one of the seminar rooms in like where you know the chairs are all in lines and you you sit back and everybody sat with each other and there was no seating plans, there was no, so the midwives sat on that row and the ODPs sat on that row, and then mental health sat back and everybody was very separate. And then in the afternoon we had, I think that was when it was the separate group. But again, there was no seating plans and no nothing, And everybody stuck to their own little cohorts. The second year we went in and they were, there was tables with already mixed groups, and it was smaller groups, with say two midwives, two nurses, two adult nurses and ODPs or whoever else, mental health, whatever was there... So we were already FORCED to mix, I guess, is the word. But actually that was quite effective because we sat down and we were like 'Oh, Hi, where are you from'? And discussed... there was already introduction, and you were forced to mix with other people. Whereas I think before, maybe it's because we were first years, and, you know, we only knew the people that were in our cohort... or maybe not, I don't know. It was nice to have that conversation. I learned a lot just from, before even the lecture started, before the learning started, I learnt a lot just from those conversations with the other people. And I think that make a big difference.	Just having contact with people from other professions clearly important to her -where groups are not required or encouraged to mingle, tend to stick to own groups the midwive sat on that row and the ODPs sat on that row, and then mental health sat back and everybody was very separate…. everybody stuck to their own little cohorts. So we were already FORCED to mix, I guess, is the word. But actually that was quite effective I learned a lot just from, before even the lecture started, before the learning started, I learnt a lot just from those conversations with the other people.

Contact Hierarchy – being eroded	MG: [00:22:50] So leading from that, I suppose, is your attitude to IPE. You said that it changed from the first year to the second year perhaps.. it might have been down to the way it was structured or whatever, Have they changed.. Clearly they have changed? Beth: [00:23:04] Yes, yes.... I wouldn't say I didn't enjoy it in the first year. We learned a lot. But there wasn't that kind of mixing. I don't think it was ... I think it was more.... We went and we attended several different talks and saw different, several different speakers rather than in second year where I think we genuinely sat with, and learned from other profession, which was lovely. MG: [00:23:34] So your attitudes have changed? Beth: [00:23:37] Yeah. MG: [00:23:37] Do you think other healthcare professionals attitudes have changed? To midwives, or student midwives from your perception, do you think... Beth: [00:23:47] I think so. Certainly the people I was sitting said I never knew it was like that...or we didn't know you had to do all of that. So I think it's going to take a while isn't it. I think health care was allowed to be a hierarchy. Like, I was surprised, I remember in the first year, I was	We learned a lot. But there wasn't that kind of mixing. I don't think it was ... I think it was more.... We went and we attended several different talks and saw different, several different speakers rather than in second year or I think we genuinely sat with, and learned from other profession, which was lovely. Just having contact with people from other professions clearly important to her use of word 'lovely' health care was allowed to be a hierarchy… I think it takes a while to break down those

IPE is a positive experience - wants more IPE Contact	surprised when I went out and the doctors, were like, 'no, call me by my first name.' I was expecting it to be like Mrs. Blah or Mr. Whoever. I think it takes a while to break down those hierarchies that were there perhaps, when other generations were in active practice. I like to think so... I do like to think so. MG: [00:24:30] So if you had any recommendations for interprofessional education, what would they be? Beth: [00:24:40] You know, I'd actually like more. I'd actually like more. I think it's quite a shame that we only do it one day, one day a year. I was in the canteen and some ODPs were preparing, no, not ODPs, paramedics, paramedic students were preparing for their obstetric emergency exam and they were talking about breech deliveries and we'd just done our complex midwifery care exam. And so one of them looked at me and was talking about breech... and I shook my head and he was like, no, that girls saying no. That kind of started a very organic conversation, and I think ... I don't see what's the harm in learning those things together. I said, I went back and I asked C, the lecturer. I said do midwives go into those sessions, and she said, Yeah, I think it's wrong, but they have a midwifery lecturer go in. And I said well what about students... 'No, I don't think so'... We were talking in the first year, we were talking about caesarean sections, and, I think I was preparing	hierarchies that were there perhaps, when other generations were in active practice. Seems to be of opinion that things are changing – expected to call Drs by title and surname but told to call them by fist name – some sort of suggestion of equalising of status That kind of started a very organic conversation – use of word 'organic' (meaning natural, informal)

IPE is a positive experience - wants more IPE Contact IPE is a positive experience - wants more IPE	for my OSCEs or something, we were in the skills lab anyway.. and my friend and I, we opened the door and the, um, the ODPs were in the theatre scrub room bit, and we walked in and we were like 'Oh, sorry, We just wanted to see what the room was. We haven't been in here and the were like no, no come in, come in, let's have a chat. And they said that they only get one or two midwife students go in and speak to their, erm, the ODPs about caesarean sections and like the procedures in there. I think it might be nice to do something together just once in a while, rather than like just the, the domestic violence or the, whatever, safeguarding that we do in the BIG days... maybe just have a few odd lectures, that would be quite nice to just mix and start a conversation and see how they feel about it, see how we feel about it. I was surprised that the paramedics couldn't do internal manoeuvres to release like a shoulder dystocia baby. And I was like, well, what if the mum, you know, what if the baby's not coming, what if they're dying - 'Well, we just hope that you get there'....OK...OK... (nervous laugh) Well, what's different that you can do to what we can do? So I think they would've, they wanted to hear what we did, just as I was interested to hear what they were doing. So I think we might benefit from having....more....please MG: [00:27:23] How would you suggest that be addressed? You said, what you would you like...	I think it might be nice to do something together just once in a while – wants more 'targetted' IPE with other professional groups - maybe just have a few odd lectures, that would be quite nice to just mix and start a conversation and see how they feel about it, see how we feel about it. So I think we might benefit from having....more....please

IPE is a positive experience - wants more IPE Learn from/about others roles IPE in placement – informal Contact	Beth: [00:27:28] Maybe mixed lectures. I mean, I don't know what their cohort sizes are, I would imagine their the same. Maybe doing a mixed lecture with half of the paramedics and half of the midwives in separate rooms and having them do their complex midwifery care, or, I don't know what else overlaps, I don't know what they learn about, and I think that's a shame, because we, you know, you go out into practice, you get your job and you just presume that they know what they're doing, and it would be quite nice to share with that, and see. Maybe I'm just nosy, I don't know (laughs). MG: [00:28:12] I think it's it's fascinating because you're talking... Between the two, you're talking about interprofessional education that's happening in placement, and interprofessional, education that's happening in University. And you, you've talked about some informal, and formal opportunities in both settings, erm, in terms of the formal lecture setting and you talked about informal conversations in the corridor. Does that informal element happen also in practice, do you think? Beth: [00:28:46] Yeah, I definitely think so. I love one of the CSWs that works.. She's, we've had some of the best conversations about upcoming training programs or whatever, and getting her ideas on things. In the staff room at the hospital, doctors and anaesthetists and midwives sit altogether. I haven't done my SCBU placement	Maybe mixed lectures Maybe doing a mixed lecture with half of the paramedics and half of the midwives in separate rooms I don't know what they learn about, and I think that's a shame, because we, you know, you go out into practice, you get your job and you just presume that they know what they're doing, and it would be quite nice to share with that, and see I love one of the CSWs…. we've had some of the best conversations ….In the staff room at the hospital, doctors and anaesthetists and midwives sit altogether.

Contact	yet so I don't know what that's like. But they certainly seem to get on very well. And I find the ones that engage in the social kind of aspect, like, just sitting in the office when you're not doing anything or you waiting for your lady to be prepped for a C-section. Those are the ones that I am less fearful of going to do the handover - that doctor, the one I was speaking about before was not ever in that staff room with us. And I wonder if maybe that's the difference. If....it's interesting, I don't like the divide necessarily. I think we work better when we know each other. Because then if you, not necessarily like each other, but if you, you can have a conversation, you can, you can be respectful and have an understanding of each other then it just seems to be a cohesive team. MG: [00:30:07] And you mentioned about knowing each other. Do, do you think that getting to know a paramedic or getting to know a obstetrician can help or hinder your working with other paramedics or other obstetricians, whereas if you've never met…. Beth: [00:30:31] Yeah. Yeah, definitely. I think, I can't see how it would ever hinder unless they've got a really bad opinion. But even then, you start a conversation don't you, like, the ones, the paramedics I was speaking to downstairs.. If I ever got a chance to sit with another paramedic, I think, I would be like, OK how do you find the complex midwifery stuff? Do you feel like you can do enough? How..what.. I mean, the ones I	Concept that informal contact leads to better working relationships due to familiarity which breaks down barriers I find the ones that engage in the social kind of aspect, like, just sitting in the office when you're not doing anything or you waiting for your lady to be prepped for a C-section. Those are the ones that I am less fearful of going to do the handover referred to dr who she had difficult experience with did not sit in staff room I think we work better when we know each other. Because then if you, not necessarily like each other, but if you, you can have a conversation, you can, you can be respectful and have an understanding of each other then it just seems to be a cohesive team. Contact with a member of a profession influences opinion of the other profession as a whole
Contact		

Contact	speaking to downstairs said most of the time a midwife arrives. 'Oh, okay. But that must be really scary for you because you can't do anything' I wonder if they all feel like that, if they all feel that isolated and that dependent on the midwives showing up, or, you know, I think they prompt a conversation. And when you have that understanding and that willingness to listen to what they're saying, it just feels best team work So, yeah, I definitely think it's beneficial to meet them and talk to them. MG: [00:31:29] I suppose what I'm after is if, if you've never met a paramedic, so where you've never met somebody from a particular profession but another profession where you have met somebody? Does the fact that you met somebody from that profession change your view of the profession as a whole, or does it make it easier for you to work with or communicate with, just simply having that contact with that one person... Beth: [00:31:57] I'd like to say no. I'd like to think that the care would be exactly the same and that you could still work in a cohesive team. But I think maybe the confidence and the... What's the word I'm looking for? You know, like ease of con.. like the familiarity, the friendliness that warmth that teams get, I think that would definitely be impacted if you hadn't met somebody before or had any understanding of what they're doing, because it can be quite intimidating can't it to go	I definitely think it's beneficial to meet them and talk to them.

Collaborative practice	into a situation where you don't know anybody. And I guess if people knew what your job was and knew something of what you've been through, there would be less of a them and us. It would be more just us. so yeah, I think so. MG: [00:32:58] If you had to sum up what you think interprofessional education is all about, what would it be? Beth: [00:33:06] Learning with people from other disciplines and other healthcare areas, to, I guess enhance, teamwork and, and communication and cohesive working together... That was not a good sentence. (laughs) MG: [00:33:31] And do you think what you've experienced so far has gone some way, to do that? Beth: [00:33:35] Definitely. Definitely. Yeah. Particularly the second year. And I know I've been speaking a lot about that, but I really, really got a lot from that. MG: [00:33:49] Was it the content of that second year session? Was it the way it was organised? You said it was?	I guess if people knew what your job was and knew something of what you've been through, there would be less of a them and us. It would be more just us When asked to sum up IPE this is the element she picks up on Learning with people from other disciplines and other healthcare areas, to, I guess enhance, teamwork and, and communication and cohesive working together very positive about second year experience
Facilitation/Organisation	Beth: [00:33:54] I think maybe the way it was organised MG: [00:33:55] Was it the setting?	Organisation key – in this case to promote contact

IPE – requires engagement Contact Requires engagement Contact	Beth: [00:33:56] Yeah, I think being on the table initially, because everybody's nervous, going into a room where you don't know anybody, everybody's nervous. But we were all going into a room where we didn't necessarily know who we were going to be sitting next to so we're all in the same boat, already there's that camaraderie isn't there. I think that was nice, I think, I know, some people didn't particularly like that because they didn't get to sit with their friends. But we're grown ups. And actually, it was really nice to have a conversation with people from other disciplines. So I think probably the way it was set up and the way it was structured more than... MG: [00:34:35] Did you, did you have a conversation with those people, who were of that opinion? Beth: [00:34:39] No, because I don't really have time for it, which sounds awful. I'm kind of of the opinion that actually we're all in it together and they probably weren't happy about not sitting with their freinds either. I don't think. But we're grown ups and we're gonna be working together. So let's work together and get the best out of it. You don't get the opportunity again. That's the one DAY in our academic YEAR where we get to sit down with the paramedics, or the mental health nurses, or the nurses, or the ODPs. And, and let's make the most of it. Let's do this thing that they want us to do, because clearly there's a	I know, some people didn't particularly like that because I didn't get to sit with their friends. it was really nice to have a conversation with people from other disciplines. So I think probably the way it was set up and the way it was structured I don't really have time for it seems to be annoyed by those who don’t engage You don't get the opportunity again. That's the one DAY in our academic YEAR where we get to sit down with the paramedics, or the mental health nurses, or the nurses, or the ODPs. And,

IPE is a positive experience – leads to improvements in practice	reason we look at the statistics and the reports on this is better for the women or this is better for patients and there's less burnout and there's less hierarchy and there's less tension in teams. So let's do it. So no, I didn't really have have the conversation because it's.. I don't have time for that. But I did say, Yeah, I kind of said, Yeah, I guess there was a conversation... I know I don't want to be negative about it. I was kind of like let's just, let's make the most of it. MG: [00:35:48] And were there people like that in your group? Beth: [00:35:49] No, no, no. We had a lovely table, actually. MG: [00:35:53] And that's just fortuitous. Beth: [00:35:56] Yeah, I was just lucky. I don't know. I like to think that they were probably all like that, with the odd few that didn't like not sitting with their friends. I suppose on any team is always gonna be some that don't want to engage isn't there.. you can't win. I feel like I've just rambled on... MG: [00:36:21] That's what I needed .. thank you. OK.	and let's make the most of it. Contact clearly important Let's do this thing that they want us to do, because clearly there's a reason we look at the statistics and the reports on this is better for the women or this is better for patients and there's less burnout and there's less hierarchy and there's less tension in teams. So let's do it. Clearly believes that outcomes are better when collaborative practice is evident
IPE requires engagement		I like to think that they were probably all like that, with the odd few that didn't like not sitting with their friends. I suppose on any team is always gonna be some that don't want to engage isn't there.. again seems to be annoyed by those who don't engage

Beth: Superordinate themes and themes		
Themes	**Page/line**	**Key words**
Learning from/about others		
Roles	1.12	we got to learn about, you know, the roles that these people do.
Understand stereotyping	4.28	That's your own prejudices
breakdown/breach prejudices	5.9	learning together then breaks down those those hierarchies and prejudices. And then you get more cohesive teams and better outcomes for women and staff
	8.22	I think it's nice to have that ... like I said before, the appreciation of their journey and their passions.
	10.26	I think it's so easy to stop thinking of everybody else as people. I think sometimes we isolate ourselves and it's nice to see.... nice to bring that together... And enforce that you are a TEAM, everybody, rather than we are a team of midwifes, or a team or whatever
	12.1	knowing the sort of people you're going to be working with, is beneficial
	12.8	I think it gives it has given me a big appreciation for what they've done to get to where they are now
	13.22	I think my own perceptions have changed a little bit - Not I like to admit that I had preconceived ideas
	13.29	I didn't realize there was that kind of level of, I guess community amongst health care providers, I didn't realize that was a thing, and that the roles, not overlapped, but like they so gently rely on each other knowing what you're doing, like, the boundaries are very respectful of each other

Contact	14.5	I'd heard, I'd heard, some not so nice things about attitudes of other people, particularly towards midwives, actually I must admit, erm, how people thought midwives were better than, I don't know, because we're more specialized or whatever...erm.. So I kind of am fighting to not have that stigma and to not be that bad team member that is then, feels like I'm better, because it's not, it's so NOT like that. So it makes me sad that those ideas have been out there in someway.
	19.6	I don't know what else overlaps, I don't know what they learn about, and I think that's a shame, because we, you know, you go out into practice, you get your job and you just presume that they know what they're doing, and it would be quite nice to share with that, and see.
	1.9	I loved the structure of this year's interprofessional education because we were at tables and we all had conversation. And I think that was very authentic
	5.1	I think that's why I got more out of the second year than I did out the first year. There wasn't really any mingling in the first year.
	5.22	I'd never had a chance to sit down with a student nurse … and I found that really helpful because you kind of get an appreciation for what they're going through
	6.13	The opportunity to mix with people from other disciplines

	6.18 9.20 10.14 13.9 15.3	I think it's just an appreciation for other people's workload that you get when you're having ***authentic conversations*** like that. It was NICE just to have a conversation and to appreciate the journey that everybody else is on. I think it's quite easy to get ***isolated*** in your own professions… to hear them training and their ***passions*** was quite like, wow, you know, that's that's amazing. It's amazing that you feel that way about that. And to see their ***passion***, then kind of gives everybody else a bit more ***respect*** for it, I think [MG]you've talked a lot about how important that is. Just just meeting people. [Beth] ***Yes*** it's nice to know, kind of, their backgrounds and maybe where they've come from and what they deal with and to have conversations that then create safety for this lady. The ODPs... in the first year, in the first year, IPE were very separate, and very kind of, they kept to their own little group and didn't particularly want to talk to anybody else, and I think that made everybody else a bit like, OK so it's us and you then. Second year, there was none of that. Maybe it is because the structure of things, I dont know, But we were very much a group from the beginning. we were in one of the seminar rooms in like where you know the chairs are all in lines and you you sit back and everybody sat with each other and there was no seating plans, there was no, so the midwives sat on that row and the ODPs sat on that row, and then mental health sat

	15.13	back and everybody was very separate… And everybody stuck to their own little cohorts.
	15.30	The second year we went in and they were, there was tables with already mixed groups, and it was smaller groups, with say two midwives, two nurses, two adult nurses and ODPs or whoever else, mental health, whatever was there... So we were already FORCED to mix, I guess, is the word. But actually that was quite effective
	17.19	I learnt a lot just from those conversations with the other people. And I think that make a big difference. I wouldn't say I didn't enjoy it in the first year. We learned a lot. But there wasn't that kind of mixing…..rather than in second year where I think we genuinely sat with, and learned from other profession, which was ***lovely***.
	18.15	one of them looked at me and was talking about breech... and I shook my head and he was like, no, that girls saying no. That kind of started a very ***organic*** conversation, and I think ... I don't see what's the harm in learning those things together
	19.29	that would be quite nice to just mix and start a conversation and see how they feel about it, see how we feel about it
	20.2	In the staff room at the hospital, doctors and anaesthetists and midwives sit altogether.
	21.10	And I find the ones that engage in the social kind of aspect……Those are the ones that I am less fearful of going to do the handover
	21.24	I definitely think it's beneficial to meet them and talk to them.

	23.12 23.26	I think maybe the confidence and the... like the familiarity, the friendliness that warmth that teams get, I think that would definitely be impacted if you hadn't met somebody before or had any understanding of what they're doing, because it can be quite intimidating can't it to go into a situation where you don't know anybody. And I guess if people knew what your job was and knew something of what you've been through, there would be less of a them and us. It would be more just us. so yeah, I think so. actually, it was really nice to have a conversation with people from other disciplines.
Hierarchy and status between professions	2.5 2.29 3.2 3.14	That's the one DAY in our academic YEAR where we get to sit down with the paramedics, or the mental health nurses, or the nurses, or the ODPs. And, and let's make the most of it. And I find there can be some hierarchy, especially with the obstetricians I think it helps the teams run well. Some of the doctors... Yes... Do have an air of superiority, I guess, But that's that's very rare.
Based on knowledge and experience	5.8 3.1	the first time I'd ever done a handover to a doctor... And he was very ***intimidating*** and kind of shot me down and picked holes in everything, and had a kind of smugness. My mentor commented on it. And that made me very apprehensive about doing it again learning together then breaks down those those hierarchies and prejudices.

	3.27 4.8	I think it's quite helpful because everybody's got their own limits of practice. well you need to know your role don't you.. So I'm going to hopefully one day be a midwife. I know what that job entails. I know... I know what my my role is within that team. I wouldn't presume to go into theatre and know where all of the equipment is…. Sometimes I think it's not really a hierarchy, though, is it? That's not... That's a different kind of thing. It's not .. senior midwife ... maybe that's a better...erm.. I don't know how the delivery suite runs, I don't know. I have a lot of respect for the midwife that co-ordinates, erm... She's in charge, but she treats us like a team rather than, you know. this is you, and this is me. I think that's a good way, that's what I mean, when they work nicely, in teams together.
Erosion of **Collaborative Practice/Teamwork**	16.29	health care was allowed to be a hierarchy… I think it takes a while to break down those hierarchies that were there perhaps, when other generations were in active practice.
Better Outcomes	5.11 7.11	you get more cohesive teams and better outcomes for women and staff, and less burnout and you're sharing the burden and appreciating each other a bit more. And everybody just popped into action. It was like the most cohesive teamwork I've ever seen. And I thought, wow. Actually, it was my whole... I

	9.7	thought it was a really positive learning experience
	10.7	I've read about the outcomes and how it can be better for everybody involved and for the professionals as well to not, you know, to feel like a valued team member.
	10.18	I think there's trust there that we work together. And when things go bad, we're in it together.
	11.10	I think I'm learning how to be a better team player, I guess
	12.12	I think it just helps it to be a little more ***cohesive.***
	12.15	you know, we're all on the same ***journey***, essentially. ***We all want the same things***.
	22.9	as long as we can all do our jobs and work well together, we all want to go to bed at night knowing that we've done the best we can and worked to the best that we can, and, and that was the real kind of theme, running through all of the education.
Respect	11.02	Learning with people from other disciplines and other healthcare areas, to, I guess enhance, teamwork and, and communication and cohesive working together
	13.4	because then you have a better ***respect*** for them. the depth of their knowledge on things like drugs and procedures and whatever was INCREDIBLE,
Requires Engagement	23.8	And I looked and thought actually I don't think I could ever do, I don't think I could ever be a nurse.
	23.19	I know, some people didn't particularly like that because they didn't get to sit with their friends. I'm kind of of the opinion that actually we're all in it together and they probably weren't happy

	24.16	about not sitting with their freinds either. I don't think. But we're grown ups and we're gonna be working together. So let's work together and get the best out of it. You don't get the opportunity again. That's the one DAY in our academic YEAR where we get to sit down with the paramedics, or the mental health nurses, or the nurses, or the ODPs. And, and let's make the most of it.
Positive Experience	8.3 9.12	I like to think that they were probably all like that, with the odd few that didn't like not sitting with their friends. I suppose on any team is always gonna be some that don't want to engage isn't there.. I think I've been quite lucky
Relevant	8.16	I don't see what could be negative about it, really. I don't see what could be wrong with it. I can't see any negatives.
Wants more	17.11 18.11	I really enjoyed it, because they are people that we will come across in our.. in our jobs I'd actually like more. I'd actually like more.
	18.28	I think it might be nice to do something together just once in a while, rather than like just the …. BIG days... maybe just have a few odd lectures, that would be quite nice
	19.1	So I think we might benefit from having....more....please
Facilitation/Organisation	22.24	Maybe mixed lectures…. Maybe doing a mixed lecture with half of the paramedics and half of the midwives
Professional Pride Pride of others has an impact	9.2	I think maybe the way it was organised

	10.20	seeing somebody have passion for their career is quite nice. And I think we got that everybody has a role to play and everybody loves their job and they've picked that job for a reason, always something behind it, there's a reason why you're a mental health nurse and not a pediatric nurse, or why you decided to do ODP rather than going to be a doctor. But there's always a reason.... erm.. and I think it's.... nice to bring that together

Appendix 6

CCCU Ethics Application and Approval

Canterbury Christ Church University

Education Faculty Research Ethics Review
Application for full review

For Faculty Office use only	
FREC Protocol No:	**Date received:**

*Your application **must** comprise the following documents (please tick the boxes below to indicate that they are attached):*

Application Form	✓
Peer Review Form	✓
Copies of any documents to be used in the study:	
Participant Information Sheet(s)	✓
Consent Form(s)	✓
Introductory letter(s)	✓
Questionnaire	✓
Focus Group Guidelines	*n/a*

Education Faculty Research Ethics Review
Application for full review

1. PROJECT DETAILS

MAIN RESEARCHER	Mark Gradwell
E-MAIL	mark.gradwell@canterbury.ac.uk
POSITION WITHIN CCCU	Senior Lecturer
POSITION OUTSIDE CCCU	
COURSE (students only)	EdD
DEPARTMENT (staff only)	Department of Allied & Public Health Professions
PROJECT TITLE	An Interpretive Phenomenological Analysis of Interprofessional Education; An investigation of the experiences of pre-registration healthcare students
TUTOR/SUPERVISOR: NAME	Sue Soan
TUTOR/SUPERVISOR: E-MAIL	sue.soan@canterbury.ac.uk
DURATION OF PROJECT (start & end dates)	October 2018 – June 2020

OTHER RESEARCHERS	

2. OUTLINE THE ETHICAL ISSUES THAT YOU THINK ARE INVOLVED IN THE PROJECT.

The research participants will be CCCU pre-registration students from the Faculty of Health and Wellbeing at Canterbury Christ Church University. Participation will be entirely voluntary. Informed consent will be obtained from all participants and confidentiality and anonymity of the participants will be ensured throughout the research process. The research project will not involve invasive or intrusive procedures participants or stress or anxiety to participants. However, it is acknowledged that these participants are students on pre-registration programmes within the Faculty of Health and Wellbeing and the researcher is a member of the academic staff within the Faculty. There is therefore the risk that students may feel pressured into participating and that there may be an unintended, hidden issue of power imbalance between the participant and researcher. Students will need to be reassured that participation is entirely voluntary and that the decision to participate or not will have no bearing on their course marks or assessment. It is already acknowledged that the researcher is a lecturer for the Diagnostic Radiography programme and because of this, students on the BSc Diagnostic Radiography course will not be included in the study.

3. GIVE A BRIEF OUTLINE OF THE PROJECT in no more than 100 words. (*Include, for example, sample selection, recruitment procedures, data collection, data analysis and expected outcomes.)* Please ensure that your description will be understood by the lay members of the Committee.

Using Interpretative Phenomenological Analysis (IPA), the research will explore the way in which pre-registration healthcare students experience interprofessional education (IPE). The study will involve pre-registration healthcare students at CCCU in two different year groups who have experienced IPE delivered in different ways. A notice will be placed on the cohort Blackboards asking for volunteers. Semi-structured individual interviews will be held with a small number of consenting selected participants twice during the research study. Interviews will be recorded and transcribed. Transcripts will be analysed, and emerging themes will be coded with the researcher considering and reflecting on his own interpretation.

4. How many participants will be recruited?	8 (4 from each cohort)
5. Will you be recruiting STAFF or STUDENTS from another faculty?	**YES** Faculty of Health and Wellbeing **IMPORTANT**: If you intend to recruit participants from another Faculty, this form must be copied to the Dean of the Faculty concerned, and to the Chair of that Faculty's Research Ethics Committee.
6. Will participants include minors, people with learning difficulties or other vulnerable people?	~~YES~~/**NO**

7. Potential risks for participants: - Emotional harm/hurt* - Physical harm/hurt - Risk of disclosure - Other (please specify) *Please note that this includes any sensitive areas, feelings etc., however mild they may seem.	Please indicate all those that apply. **YES**/~~NO~~ ~~YES~~/**NO** ~~YES~~/**NO**
8. How are these risks to be addressed?	It is anticipated that the study will not induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life. The researcher will at all times be aware of the potential for students to be become upset when discussing their own experiences, and will approach the conversations in a professional, sensitive manner. However, if any participant does demonstrate or indicate that they are experiencing any such emotions because of participating in the study, their participation will be terminated if they so wish, and the student's personal academic tutor contacted to offer appropriate support or signpost the student to relevant agencies.
9. Potential benefits for participants: - Improved services - Improved participant understanding - Opportunities for participants to have their views heard. - Other (please specify)	Please indicate all those that apply. **YES**/~~NO~~ **YES**/~~NO~~ **YES**/~~NO~~

10. How, when and by whom will participants be approached? Will they be recruited individually or en bloc?	A notice will be placed on the cohort Blackboards asking for volunteers to participate in the study. Students who express an interest in the study will be contacted by the researcher with further information, including the participant information sheet. From those students who volunteer to participate, 4 will be selected

	from each cohort. It is anticipated that volunteers permitting, participants will be purposively selected to reflect the same range of pre-registration programmes in each cohort. If this is not possible then participants will be randomly selected from the volunteers from each cohort
11. Are participants likely to feel under pressure to consent / assent to participation?	~~YES~~/NO
12. How will voluntary informed consent be obtained from individual participants or those with a right to consent for them? - Introductory letter - Phone call - Email - Other (please specify)	Please indicate all those that apply and add examples in an appendix. **YES**/~~NO~~ ~~YES~~/**NO** **YES**/~~NO~~

13. How will permission be sought from those responsible for institutions / organisations hosting the study? - Introductory letter - Phone call - Email - Other (please specify)	Please indicate all those that apply and add examples in an appendix. ~~YES~~/**NO** ~~YES~~/**NO** **YES**/~~NO~~
14. How will the privacy and confidentiality of participants be safeguarded? (Please give brief details).	Confidentiality and anonymity of the participants will be ensured throughout the research process. Names of each participant will be changed to preserve anonymity. Any documentation identifying each participant will be kept on a password-protected computer. Any identifiable data will be kept separately from anonymised data in password protected files. Each interview will be recorded and transcribed verbatim. Once the researcher has checked that the recording and the transcript are the same, the recording will be erased. Identifying details will be removed from any transcript and will not be included in any final report and/or any publication to make it impossible to identify any participants.
15. What steps will be taken to comply with the Data Protection Act? - Safe storage of data - Anonymisation of data - Destruction of data after 5 years - Other (please specify)	Please indicate all those that apply. **YES**/~~NO~~ **YES**/~~NO~~ **YES**/~~NO~~
16. How will participants be made aware of the results of the study?	Participants will be told that they can ask for the findings from the study if they wish to see them.
17. What steps will be taken to allow participants to retain control over audio-visual records of them and over their creative products and items of a personal nature?	Participants will be given the opportunity to see a transcript of the interview afterwards to verify the content. Once the researcher has checked that the recording and the transcript are the same, the recording will be erased. If they wish they can be given the audio recording to destroy themselves.

18. Give the qualifications and/or experience of the researcher and/or supervisor in this form of research. (Brief answer only)	The researcher has limited experience in IPA and qualitative research. However, he has been introduced to and studied the methodologies as part of a taught EdD. It is this introduction which has stimulated interest in IPA and led to this being the chosen methodology. The supervisor Dr Sue Soan has extensive experience in qualitative research methodologies and has previously supervised a PhD student using IPA.

19. If you are NOT a member of CCCU academic staff or a registered CCCU postgraduate student, what insurance arrangements are in place to meet liability incurred in the conduct of this research?	

Attach any:

Participant information sheets and letters
Consent forms
Data collection instruments
Peer review comments

DECLARATION

- I certify that the information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I certify that a risk assessment for this study has been carried out in compliance with the University's Health and Safety policy.
- I certify that any required CRB/VBS check has been carried out.
- I undertake to carry out this project under the terms specified in the Canterbury Christ Church University Research Governance Handbook.
- I undertake to inform the relevant Faculty Research Ethics Committee of any significant change in the question, design or conduct of the study over the course of the study. I understand that such changes may require a new application for ethics approval.
- I undertake to inform the Research Governance Manager in the Graduate School and Research Office when the proposed study has been completed.
- I am aware of my responsibility to comply with the requirements of the law and appropriate University guidelines relating to the security and confidentiality of participant or other personal data.
- I understand that project records/data may be subject to inspection for audit purposes if required in future and that project records should be kept securely for five years or other specified period.
- I understand that the personal data about me contained in this application will be held by the Research Office and that this will be managed according to the principles established in the Data Protection Act.

Researcher's Name: Mark Gradwell

Date: 20/11/2018

Canterbury Christ Church University

8th January 2019

18/EDU/006

Dear Mark,

Project title: An Interpretive Phenomenological Analysis of Interprofessional Education; An investigation of the experiences of pre-registration healthcare students

Further to the email from [redacted] this is formal confirmation of the approval of your ethics application by Chairs Action.

Please do let us know when you have completed the work so that we can update our records.

Good luck with this study.

Yours sincerely,

[redacted]

[redacted]
Chair, Faculty of Education Research Ethics Committee.